DYNAMIC ORTHOTICS and PROSTHETICS

MEDICAL CENTER:	7015 ALMEDA ROAD, HOUSTON, TX 77054	TEL. (713) 747-4171	FAX (713) 747-4249
SUGAR LAND:	4915 SOUTH MAIN, SUITE 115, STAFFORD, TX 77477	TEL. (281) 980-5300	FAX (281) 980-3595
THE WOODLANDS:	19221 I-45 NORTH, SUITE 480, SHENANDOAH, TX 77385	TEL. (281) 419-6638	FAX (281) 419-7098

76-0524096

POST OPERATIVE BRACING FORM

Patient Name:	
DOB:	
Address:	
Telephone:	

Estimated Length of Need:	__6___ Weeks	_____Months	_____Years	_____Lifetime
Diagnosis:				
Prognosis:				
Justification:	This device will be worn 24 hours per day for 6 weeks to optimally position the upper extremity for stability at the shoulder and brachial plexus following surgery.			
Date of Surgery:				
Type of Surgery:				

Description/Usage of Supplies:	**Quantity**	**Modifier**
L3971 Shoulder-elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated	1	

BRACE TYPE:	____Modified Airplane	____Modified Gunslinger

Signature of physician certifies that the above represents his/her judgment of the patient's need for the item.

IMPORTANT: This form must be signed and dated by the prescribing physician before the prescribed item(s) may be considered for payment.

PHYSICIAN NAME:	**RAHUL K. NATH, M.D.**	UPIN:	**F30178**
ADDRESS:	**2201 W. HOLCOMBE, SUITE 225**		
CITY, STATE, ZIP	**HOUSTON, TX 77030**		
TELEPHONE	**(713) 592-9900**	**FAX:**	**(713) 592-9921**

_____ Physician Signature

_____ Date

- **☐ Complete all gray areas.**
- **☐ Have Dr. Nath sign and date LMN.**
- **☐ Attach Patient Demographic sheet.**
- **☐ Attach medical records indicating patient history and treatment.**
- **☐ Fax all to 713-747-4249.**

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