DETAILED WRITTEN ORDER

PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY (CMN)

PATIENT INFORMATION:				DATE OF ORDER:	
Last Name	**First Name**	**Middle Initial**	**Gender**	**Date of Birth**	
Address		**City**		**State**	**Zip Code**
Phone #	**Office Use:**				

PRIMARY INSURANCE:	Member ID:	Group #
Secondary Insurance Company	**Member ID**	**Group #**

PRODUCT CODE	DESCRIPTION	R	L	Both	QTY
L3960	SEWHO; SHOULDER BRACE (OTS)	____	____	_____	____

DIAGNOSIS(es) [ICD-10]:
(Please check at least one)

- ☐ **M19.011, M19.012 UNILATERAL OSTEOARTHRITIS; SPECIFY R or L** _____
- ☐ **M75.51, M75.52 UNILATERAL BURSITIS; SPECIFY R or L** _____
- ☐ **M25.411, M25.412 PAIN IN SHOULDER; SPECIFY R or L** _____
- ☐ **ADDT'L DIAGNOSIS:** _____

CERTIFICATE OF MEDICAL NECESSITY:
(Please check at least one)

- ☐ **TO REDUCE PAIN BY RESTRICTING MOBILITY OF THE SHOULDER/ELBOW;**
- ☐ **TO FACILITATE HEALING FOLLOWING AN INJURY TO THE SHOULDER/ELBOW;**
- ☐ **TO FACILITATE HEALING FOLLOWING A SURGICAL PROCEDURE ON THE SHOULDER/ELBOW;**
- ☐ **TO OTHERWISE SUPPORT OR STRETCH WEAK SHOULDER/ELBOW TISSUES AND/OR DEFORMITIES**

I understand that I am prescribing the above items(s), for the period(s) indicated, due to patient's needs and diagnosis(es).
I certify that the above item(s) is/are medically necessary for the patient's functional restoration: Is/are reasonable, medically necessary and not a convenience item(s): and that I am the attending physician.

Physician Name	Phone #	Fax #	
Address	**City**	**State**	**Zip Code**
Physician Signature	**Date Signed**	**NPI #**	

Regenesis - St. John's Medical
1704 Southside Blvd. Suite 2
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Phone: 1-904-783-9363

Regenesis Health Services, Inc.
dba St. John's Medical
A Member of the Care Collective

RETURN FAX: 1-888-430-8776 **ALTERNATIVE FAX: 904-783-0995**

PATIENT CONSULTATION SUMMARY - CHART NOTES

DATE: _____

PATIENT LAST NAME	PATIENT FIRST NAME	DOB	AGE	GENDER

PHYSICIAN	PATIENT CHIEF COMPLAINT	PT WEIGHT	PT HEIGHT

PATIENT HISTORY

VISIT NOTES:

ALLERGIES:	
NAME	REACTION

MEDICATIONS:					
NAME	CURRENT	DATE STARTED	DATE ENDED	FREQUENCY	DOSAGE

DIAGNOSIS/IMPRESSION:

PLAN:

PRESCRIBED MEDICINE:			ADDITIONAL REQUESTED DIAGNOSTICS:
NAME	DOSAGE	INSTRUCTIONS	

PHYSICIAN SIGNATURE:	DATE: