FOOT AND ANKLE PRESCRIPTION FORM

Patient Name: ________________________________________________________ Date: ____________________

**DX:**
- __Achilles contracture  727.81
- __Instability of Joint/Ankle  718.87
- __Achilles tendonitis/bursitis  726.71
- __Ankle fusion  755.69
- __Ankle osteoarthritis 715.17
- __Apophysitis  732.5
- __Arthritis (Osteo)  719.60.
- __Arthritis (Rheum)  714.0
- __At Risk/History or Fall  (V15.88)
- __Bunion  727.1
- __Heel spur  726.73
- __Cavovarus foot (acq)  735.75
- __Cavus foot  736.73
- __Charcot  713.5
- __Charcot-Marie-Tooth: 356.1
- __Claw toe  735.5
- __CVA-other late effects: 438.9
- __Diabetes 250.________ (must include 2 digits)
- __DJD 715.0, 715.______
- __Drop Foot-other: 736.79
- __Equinus foot 736.72
- __Gait abnormality/ staggering  781.2
- __Hallux Rigidus  735.2
- __Hallux Valgus (acq.) symptomatic  735.0
- __Hammer toe  735.4
- __Leg Length Discrepancy acq.  736.81
- __Metatarsalgia  726.70
- __Muscle weakness  728.87
- __Neuroma  355.6
- __Peroneal Tendonitis  726.79
- __Pes planus (acq.)  734.
- __Pes planus (cong.)  754.61
- __Plantar fasciitis  728.71
- __Plantar fasciitis Night Splint (L4396)
- __Rupture, Tendon, Ankle & Foot (727.68)
- __Sesmoiditis  733.99
- __Sesmoiditis  733.99
- __Sesmoiditis  733.99
- __Stress fracture unspec.  733.10
- __Tarsal tunnel  355.5
- __Tendonitis, tibialis (727.68)
- __Tendinitis, tibialis posterior or anterior  736.72
- __Unspecified deformity of the ankle/foot, acq.: 736.70
- __Other: ____________________________

**RX:**
- __Foot orthotic:
  - ____Dress Orthotic: Flats or Heels (Cobra)
  - ____Casual/everyday (Semi-Rigid)
  - ____Sport (all Semi-Rigid except Soccer/Cycling)
  - ____Highly Inverted _____° (for PTTD/ pronation)
  - ____Hallux Rigidus Type (carbon fiber hallux support)
  - ____Accommodative: Diabetic RA
  - ____Toe Filler with arch support (L5000)
- __Shoes:
  - ____Shoes w/ depth/stability (Casual/Dress/Sandal)
  - ____Athletic Shoes
  - ____Diabetic Shoes with OTS inlays ( 3 2 1 pairs)
  - ____Custom Molded with orthoses (3 2 1 pairs)
- __Pneumatic/Non Pneumatic Walker
  - ____Pneumatic Walker (Ossur): Lt.  Rt.
    Presence of edema (782.3)
  - ____Non Pneumatic Walker (Ossur)  Lt.  Rt.
- __Ankle Brace/ OTC AFO
  - ____Gameday (Ossur) (L1906)
  - ____Bledsoe Axiom (L1971)
  - ____AirHeel (Aircast) (L1902)
  - ____Peromax AFO (L1951)
  - ____Exoform-strap Ankle (Ossur) (L1906)
- __Other:
  - ____Compression Hose  30-40 mmhg
    Jobst 30-40 mmg Circaid 30-40mmg
  - ____Plantar Fasciitis Night Splint (L4396)
  - ____________________________

Anticipated Length of need: 1 mos  3 mos  6 mos  1 year  > 1 year
Goals of treatment: Resolution of symptoms, stabilization of the injured area, reduction of pain, strengthening of the anatomical area.

I hereby certify that the product prescribed above is absolutely needed in order to support/stabilize or facilitate healing for the condition that they have presented with. The items were dispensed in new, not substandard, condition and the patient was verbally taught how to use the product at home. Wear, break-in information was dispensed along with the 30 DME supplier standards.

Physician Signature __________________________________________ Date _____________________