ADONIS

DME PRESCRIPTION FORM

ICARUS
609 E. Market St., Ste. 114, Charlottesville, VA 22902
P: 888.492.1101 / F: 434.270.7278
E: order@icarusmedical.com

Patient Name: ______________________ DOB: __________ Height: ________ Weight: ________
Address: ______________________
City: ____________ State: _____ Zip: _______
Phone Number: ______________________
Insurance Carrier: ______________________
Member ID: ______________________

1. Choose Primary Indication (Required)

LEFT

- ❑ M17.12 Left knee **osteoarthritis**
- ❑ M23.207 Meniscus derangement, old injury
- ❑ M23.307 Other meniscus derangement

RIGHT

- ❑ M17.11 Right knee **osteoarthritis**
- ❑ M23.206 Meniscus derangement, old injury
- ❑ M23.306 Other meniscus derangement

- ❑ M17.0 **Bilateral** primary osteoarthritis of knee
- ❑ **OTHER:** ______________________

2. Choose Secondary Indication (Required)

- ❑ M23.52 **Left** knee instability
- ❑ M23.51 **Right** knee instability

NOTE: Primary + Secondary indication and custom brace justification must be noted in chart/notes. Knee instability may be justified by objective description of joint laxity shown by varus/valgus instability test, anterior/ posterior DRAWER test, or Lachman test.

Additional Comments: ______________________

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2. I am ordering a...

❑ Custom Knee Brace L1844

I certify that I am ordering a CUSTOM **Adonis** knee orthosis, **L1844** because an OTS brace has not been effective in treating their symptoms.

Upon my exam the patient has one of thed following: (check one)

- ❑ A deformity of the leg or knee
- ❑ The leg is too small to fit an off the shelf orthosis
- ❑ The leg is too large to fit an off the shelf orthosis
- ❑ Minimal muscle mass upon which to suspend orthosis

❑ OTS (Off-the-Shelf) Knee Brace L1843 or L1851

I certify that I am ordering an OTS **Adonis** knee orthosis.

Measurements:

Calf ______ in

NOTE: The circumference measurement of the calf is to be taken 6 inches below the knee center. Reference sizing chart below to ensure an OTS brace is the proper selection.

Prognosis: ______________________
Duration: ______________________
Expected Therapeutic Effect: ______________________

NO SUBSTITUTION OF THIS DEVICE ALLOWED
**AS THERE IS NO CLINICALLY EQUIVALENT*

Ordering Physician (PRINT): ______________________
Ordering Physician (Signature/No Stamp):

____

Date: ________ NPI Number: ______________________

Size	Inches
XS (x=1)	9 - 11 in.
S (x=2)	11 - 14 in.
M (x=3)	14 - 16 in.
L (x=4)	16 - 18 in.
XL (x=5)	18 - 20 in.

Please fax the completed form, medical notes, and insurance cards to

(434) 270-7278