

READI STEADI®

Anti-Tremor Orthotic Glove System

PHYSICIAN ORDER: Letter of Medical Necessity

1. Name of Patient: _____
Signature of Patient: _____
Date: _____ DOB: _____
Telephone: _____ Email: _____

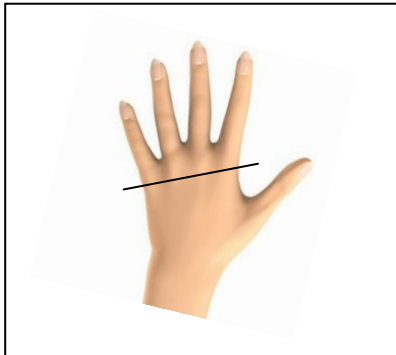
2. Indications:

- Conservative management of hand and arm tremors associated with diagnosis of but not limited to: Parkinson's, Essential Tremor, dystonia, PTSD, psychological disorders, and Multiple Sclerosis.
- Average of 50% or more reduction in resting, action and dystonic hand and arm tremors.
- Normal skin integrity with no evidence of wounds, bruising or severe allergies.
- Management or residual tremors after DBS and/or contralateral side.
- Intolerance to medications routinely prescribed for tremor symptoms.

Contraindications:

- Recent shoulder, arm or hand injury
- Unmanaged arthritis or swelling of armor hand
- Severe intolerance to moderate compression garments
- Acute MS and/or other auto-immune exacerbation
- Severe shoulder subluxation, dislocation and/or hemiplegia

3. Hand and Arm Measurements:



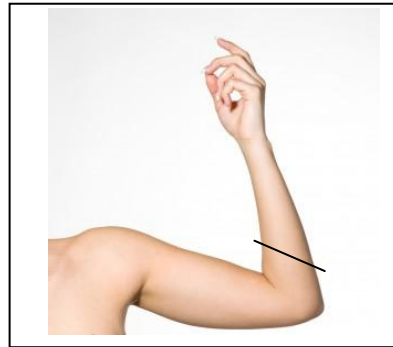
Right:

_____ " inches

Left:

_____ " inches

Measure across knuckles (MPs) of hand.
Please do not wrap tape around hand.



Right:

_____ " inches

Left:

_____ " inches

Measure around the forearm 2 inches below elbow crease.

4. The REDI-Steady® is medically necessary for this patient's medical condition ICDIO: _____

Physician's Signature

Date

Phone Number

FOR OFFICE USE ONLY:

ASSESSMENT:

Left Hand _____

Right Hand _____

Left Arm _____

Right Arm _____

APPLICATION RECEIVED ON _____

PRODUCT ORDERED ON _____

FOLLOW-UP APPT. COMPLETED ON _____

NOTES: