READI STEADI®

Anti-Tremor Orthotic Glove System

PHYSICIAN ORDER: CERTIFICATE OF MEDICAL NECESSITY
OT EVALUATE AND TREAT

Patient's Name: _____Date: _____

Patient's DOB: _____Patient's Phone Number:_____

Patient's Email (required):_____

The custom orthoses are medically necessary for this patient's medical condition. ICD -10: _____

INDICATIONS:

- Conservative management of hand and arm tremors associated with diagnosis of, but not limited to: Parkinson's, Essential Tremor, dystonia, PTSD, other psychological disorders, and Multiple Sclerosis.
- Average of 50% or more reduction in resting, action and dystonic hand and arm tremors.
- Management of residual tremors after DBS and/or for the contralateral side.
- Intolerance to medications routinely prescribed for tremor symptoms.

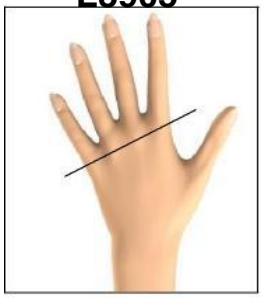
CONTRAINDICATIONS:

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

CUSTOM FABRICATED HAND ORTHOSIS:

Hand and Arm Measurements:

L3905



Right Quantity _____

_____ inches

Left Quantity _____

_____ inches

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

CUSTOM FABRICATED ARM ORTHOSIS:

L3702

Right Quantity _____

_____ inches

Left Quantity _____

_____ inches

Measure around the forearm 2 inches below the elbow crease.
Please wrap tape measure around forearm.

Physician's Printed Name **Physician's Signature** **Date**

Physician's Phone Number **Physician's Fax Number** **Physician's NPI**