READI STEADI®

Anti-Tremor Orthotic Glove System

PHYSICIAN ORDER: Letter of Medical Necessity

1. Name of Patient:____
Signature of Patient: ____
Date: ______________________________ DOB: __________________
Telephone: ______________________ Email: ______________________

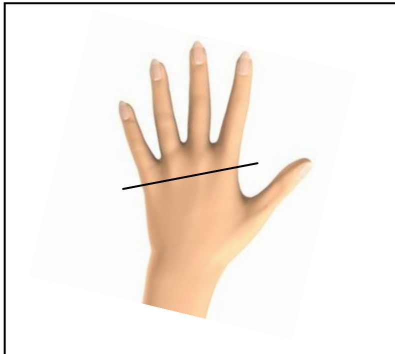
2. Indications:

- Conservative management of hand and arm tremors associated with diagnosis of but not limited to: Parkinson's, Essential Tremor, dystonia, PTSD, other 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 arm or 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:



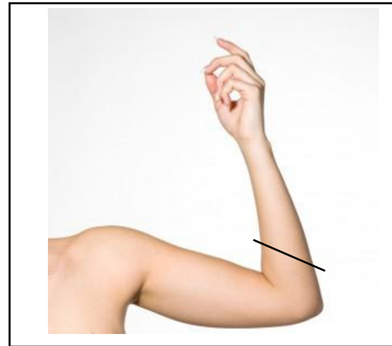
Right:

_____" 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 Readi-Steadi® is medically necessary for this patient's medical condition ICDIO: ________________

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Physician's Signature **Date** **Phone Number**

FOR OFFICE USE ONLY:	
ASSESSMENT:	☐ APPLICATION RECEIVED ON ______________________
Left Hand ________	☐ PRODUCT ORDERED ON ________________________
Right Hand ________	☐ FOLLOW-UP APPT. COMPLETED ON _________________
Left Arm ________	NOTES:
Right Arm ________	