

READI STEADI®

Anti-Tremor Orthotic Glove System

PHYSICIAN ORDER: Letter of Medical Necessity OT Evaluate and Treat

1. Name of Patient: _____

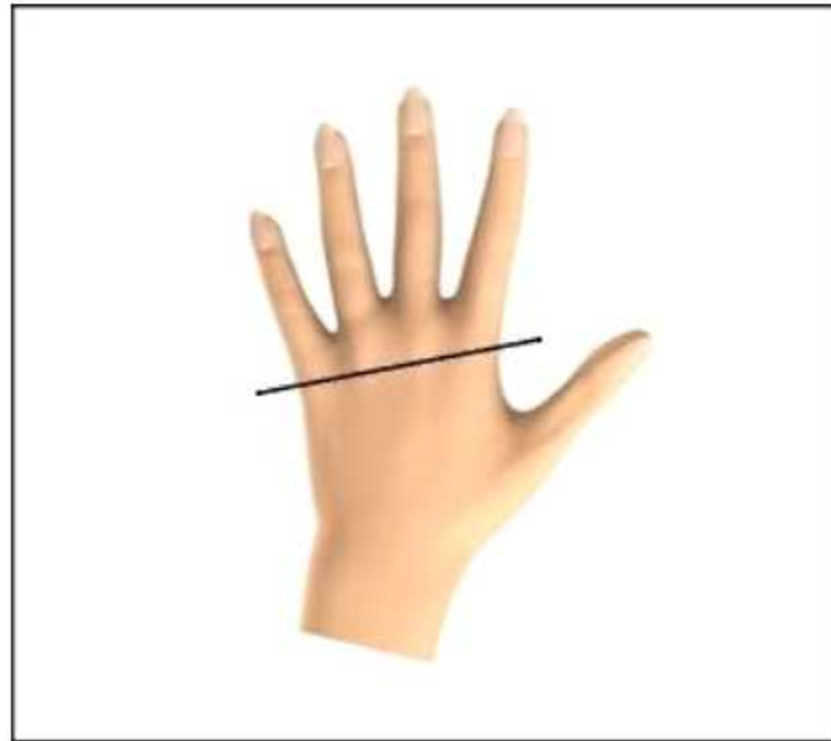
Date: _____ DOB: _____

Telephone: _____ Email: _____

2. Indications: Contraindications:

- 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.
- 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

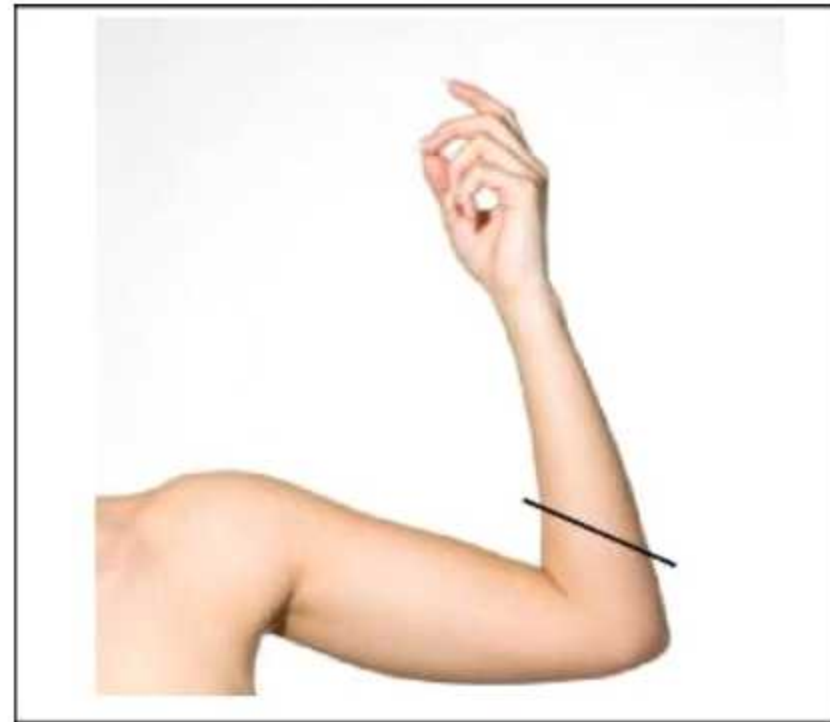
3. Hand and Arm Measurements: (If patient is not present for measurements, we will contact the patient for them.)



Right:
Hand
_____ " inches

Left:
Hand
_____ " inches

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



Right:
Arm
_____ " inches

Left:
Arm
_____ " inches

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

4. The Read-Steady® is medically necessary for this patient's medical condition ICD-10:

Physician's Signature

Physician's Printed Name

Date

Phone Number

Physician's NPI:

FOR OFFICE USE ONLY:

ASSESSMENT:

Left Hand _____
Right Hand _____
Left Arm _____
Right Arm _____

Application Received on: _____
Production ordered on: _____
Follow-up Appt Completed on: _____
Notes: _____

