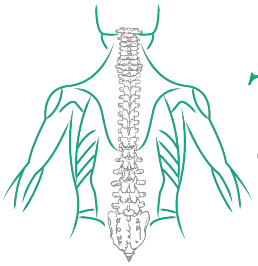

TIERNEY
ORTHOTICS AND PROSTHETICS

REQUEST FOR DURABLE MEDICAL EQUIPMENT

PATIENT NAME _____ DOB _____

DIAGNOSIS _____ MRN _____

FREQUENCY _____ LENGTH OF NEED _____
FOR LYMPHEDEMA, EVERY 6 MONTHS IS RECOMMENDED. FOR LYMPHEDEMA, LIFETIME IS RECOMMENDED.

THERAPIST _____

THERAPIST RECOMMENDATIONS (INCLUDE JUSTIFICATION FOR CUSTOM MADE GARMENTS):

_____

_____

UPPER EXTREMITY

- ☐ GAUNTLET
- ☐ GLOVE
- ☐ ARMSLEEVE
- ☐ TORSO
- ☐ BREAST PROSTHESIS
- ☐ MASTECTOMY BRAS

LOWER EXTREMITY

- ☐ KNEE HIGH
- ☐ THIGH HIGH
- ☐ PANTYHOSE
- ☐ BANDAGES
- ☐ DONNING DEVICE

- ☐ 18-20
- ☐ 20-30
- ☐ 30-40
- ☐ 40-50

LEFT | RIGHT | BILAT QTY _____

SPECIFICS:

_____

_____

_____

_____

☐ OTS ☐ CUSTOM (MEASUREMENTS ATTACHED) ☐ NIGHT ☐ BURN

MEASURED BY:

- ☐ TIERNEY O&P
- ☐ THERAPIST

DELIVERY:

- ☐ FITTED BY TIERNEY
- ☐ SHIP TO PATIENT ($22)
- ☐ PICK UP IN OFFICE
  - GREENSBORO
  - WINSTON
  - WILKESBORO

HAS THE PATIENT RECEIVED GARMENTS FROM ANOTHER PROVIDER? _____ DATE _____

DOES THE PATIENT WANT TO BE CONTACTED WHEN THEY ARE ELIGIBLE FOR MORE GARMENTS? ☐ YES ☐ NO

DOES THE PATIENT HAVE LYMPHEDEMA? _____

I AGREE WITH THE ABOVE RECOMMENDATIONS ABOVE AND PRESCRIBE THE LISTED GARMENT.

REFERRING PHYSICIAN _____

SIGNATURE _____ DATE _____

TIERNEY O&P 1345 WESTGATE CENTER, SUITE B WINSTON SALEM, NC 27103
PLEASE FAX OR EMAIL PDF ATTACHMENT TO: 866-403-2483 TIERNEY@M.MEDSENDER.COM