Imperial Medical Management, Inc.

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PROVIDER PRESCRIPTION FOR DURABLE & HOME MEDICAL EQUIPMENT

Patient Name: ____ D.O.I. ______-_______-______

SS # : ______________-__________-________________ D.O.B. ________-___________-_______________

Diagnosis: ____

BRACING	Non-Custom ☐ Dynamic Splint ☐ LSO ☐ Hinged ☐ Splint ☐ Other ☐ Immobilizers *(Please specify):* ___________________	☐ Ankle ☐ Elbow ☐ Knee ☐ Shoulder ☐ Spinal ☐ Wrist	☐ XS ☐ S ☐ M ☐ L ☐ XL ☐ XXL
THERAPY	☐ Cold/Heat Therapy ☐ Exercise Kits ☐ Post - Op	☐ Purchase ☐ Rental ☐ 1 mo. ☐ 2 mo. ☐ 3 mo.	☐ Ankle ☐ Elbow ☐ Knee ☐ Shoulder ☐ Spinal ☐ Wrist
SURGERY	☐ Pain Infusion Pumps Surgery date: ____ Facility: ____ ☐ 48 Hours ☐ 96 Hours		
ELECTROTHERAPY TREATMENT	☐ Micro – Z Stimulation ☐ Electrodes: _____ pairs ☐ Interferential Stim ☐ TENS Unit	☐ Purchase ☐ Rental ☐ 1 mo ☐ 2 mo☐ 3 mo	☐ Ankle ☐ Elbow ☐ Knee ☐ Shoulder ☐ Spinal ☐ Wrist
BONE STIMULATION	☐ Long Bone ☐ Spinal ☐ Cervical		
HOME EQUIPMENT	☐ Wheelchair ○ Standard ○ Motorized ☐ Walker ☐ Crutches ☐ Cane		

Physician's Name ____________________________Signature ___________________ Date __________