Neurolutions

IpsiHand Prescription & Assessment Form

Fax to 323-300-2410 *or* **email to Rx@neurolutions.com** | **REQUIRED ATTACHMENTS:** Relevant medical records

PATIENT INFORMATION

Order Date: _____

FIRST NAME: _____ LAST NAME: _____ DATE OF STROKE: _____

DATE OF BIRTH: _____ M: ☐ F: ☐

PHONE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CLINIC NAME _____ PHONE _____ FAX _____ CONTACT NAME _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

MEDICAL NECESSITY ASSESSMENT: *This information must be supported in the patient's medical record and a copy of the record must accompany this prescription.*

Therapies or treatments tried and/or considered (Check all that apply)

- ☐ Occupational and/or Physical Therapy Program
  - ☐ ADL Training
  - ☐ Range of Motion
  - ☐ Strengthening
  - ☐ Biofeedback Training
  - ☐ Task-Specific Training
  - ☐ Constraint-Induced Movement Therapy
  - ☐ Functional Electrical Stimulation
  - ☐ Orthotic Management
  - ☐ Home Exercise Program
  - ☐ Neuromuscular Re-education
- ☐ Pharmacological Management (Spasticity Management)
- ☐ Other _____

Reasons why the therapies or treatments failed, are contraindicated or inappropriate (Check all that apply)

- ☐ Decreased active range of motion of the upper extremity due to impaired coordination and muscle weakness
- ☐ Muscle weakness limits ability to initiate functional movements with the upper extremity
- ☐ Decreased independence for completing ADL's; requires assistance due to decreased upper extremity functional use
- ☐ Lack of coordination (gross motor and fine motor) limit functional use of upper extremity
- ☐ Decreased ability to motor plan and sequence functional upper extremity movements independently
- ☐ Patient's gains and functional improvements have plateaued trialed therapies
- ☐ Other _____

Rx: IpsiHand Upper Extremity Rehabilitation System (HCPCS: E0738) | Check affected upper extremity ☐ Left ☐ Right

Diagnoses: (List ICD-10 codes for primary and secondary diagnoses)

1. _____ 2. _____

Physician HIPAA Authorization (For Neurolutions Patient Insurance Support Program)

By signing this prescription, I attest and certify that:

- The patient indicated herein has requested that Neurolutions provide insurance support services
- The information and documentation provided is accurate and complete to the best of my knowledge
- This information is provided as an information service only
- Neurolutions assumes no responsibility for and does not guarantee the quality, scope or availability of reimbursement support
- These patient support services have no independent value to providers
- I acknowledge that Neurolutions will collect and have on file a signed copy of a current and complete patient HIPAA authorization form, permitting this office to share the patient's protected health information with Neurolutions

PHYSICIAN SIGNATURE _____ DATE _____ EMAIL _____

PHYSICIAN NAME [PRINT] _____ NPI _____ TAX ID _____