

**PATIENT INFORMATION**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **ALT PHONE:** \_\_\_\_\_ **M**  **F**   
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **ALT CONTACT:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DIAGNOSIS**

- Total knee replacement (V43.65)       Osteoarthritis knee (715.96)       Knee Arthrofibrosis (718.56)  
 LCL Tear (844.0)       MCL Tear (844.1)       ACL/PCL Tear (844.2)  
 Other: \_\_\_\_\_

**INSURANCE**

**Primary:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group:** \_\_\_\_\_  
**Secondary:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group:** \_\_\_\_\_

**KNEE REPLACEMENT SURGERY INFORMATION**

Total knee replacement surgery scheduled on this date: \_\_\_\_\_  
Total knee replacement surgery scheduled at this facility: \_\_\_\_\_

**KNEE CPM PHYSICIAN ORDERS**

- Knee continuous passive motion (CPM) therapy unit to begin no later than 2nd day after surgery and at default settings of:  
 Left knee     Right knee      Extension: 0°.      Speed: 60° per minute.  
Flexion: Starting 40°, increasing by 2° - 5° daily as tolerated with final flexion of 90°.  
Frequency: Use daily for 1-2 hours per session, 3 times per day for 21 days.
- Knee continuous passive motion (CPM) therapy unit to begin no later than 2nd day after surgery and at settings below. Use default settings above for any settings left blank.  
 Left knee     Right knee      Extension (0° to -10°): \_\_\_\_\_°.      Speed (30° to 150°): \_\_\_\_\_° per minute.  
Flexion (30° to 120°): Starting \_\_\_\_\_°, increasing by \_\_\_\_\_° daily as tolerated with final flexion of \_\_\_\_\_°.  
Frequency: Use daily for \_\_\_\_\_ hours per session, \_\_\_\_\_ times per day for \_\_\_\_\_ days.

**MEDICAL EQUIPMENT PHYSICIAN ORDERS**

- Manual wheelchair with *footrests* for use up to three months after date of surgery.  
 Manual wheelchair with *elevating leg rests* for use up to three months after date of surgery.  
 Rolling walker.       Standard walker.       Hemi walker.  
 Standard cane.       Quad cane.       Aluminum crutches (pair).  
 Bedside commode.       Drop arm bedside commode.  
 Other: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

This equipment is medically necessary for this patient's well being. It is reasonable and necessary in reference to accepted standards of medical practice for this condition, and it is not prescribed as a convenience. Unless otherwise noted, the estimated period of medical necessity is 99 months, or lifetime.

**PRESCRIBING PHYSICIAN INFORMATION**

**PHYSICIAN NAME:** \_\_\_\_\_ **NPI:** \_\_\_\_\_  
**PHYSICIAN SIGNATURE: X** \_\_\_\_\_ **DATE: X** \_\_\_\_\_