CAPSTONE
ORTHOTICS & PROSTHETICS

106 PECAN DRIVE
FRIENDSWOOD, TX 77546
Tel: (713)397-9558
Fax: (833)915-0204

Dispensing Order

Please complete form below in its entirety and if possible, send **patient demographics** with insurance information. Please also include **physician chart notes** pertaining to the patient's orthotic and/or prosthetic needs.

Patient Information

Full Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Height: _____ FT ☐ CM ☐ Weight: _____ LBS ☐ KG ☐

Treating Diagnoses/ ICD 10 Codes: _____

_____

_____

Device Prescribed

Affected Side: RT ☐ LT ☐ BL ☐ Length of Need: _____ Prosthetic Functional Level: K0 ☐ K1 ☐ K2 ☐ K3 ☐

Device Prescribed: _____

_____

_____

Physician Information and Certifying Signature

I certify that the above procedures and any repair and/or parts to maintain proper fit and function are appropriate for this patient and are deemed medically necessary.

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Signature (No Stamps): _____ Date: _____

Physician Name: _____ NPI : _____

Address: _____
Street Address *Phone Number*

_____
City *State* *ZIP Code*