CMF OL1000

Bone Growth Stimulator Prescription and Medical Necessity Form

Patient Name				Home #	
Address				Work #	
City	State	Zip	SSN	Birth date	Sex
Physician Name		Office Contact		Phone #	
Practice Name		NPI #		Fax #	
Address		City	State	Zip	

INSURANCE INFORMATION

Primary Insurance		**Secondary Insurance**	
☐ HMO ☐ PPO ☐ IND ☐ POS ☐ Workers' Compensation ☐ Auto Liability ☐ Medicaid ☐ Medicare ☐ Other ____________		☐ HMO ☐ PPO ☐ IND ☐ POS ☐ Workers' Compensation ☐ Auto Liability ☐ Medicaid ☐ Medicare ☐ Other ____________	
Name of Insured	Birth date	Name of Insured	Birth date
SSN	Relation to Patient	SSN	Relation to Patient
Insurance Carrier		Insurance Carrier	
Address		Address	
City State Zip		City State Zip	
Policy / Claim No.	Subscriber / ID No.	Policy / Claim No.	Subscriber / ID No.
Insurance Co. Phone #	Contact	Insurance Co. Phone #	Contact
Employer of Insured		Phone #	Contact

MEDICAL SUMMARY

(To be completed by the prescribing individual only)

Primary Diagnosis

☐ Nonunion ☐ No clinically significant evidence of healing

☐ Other ________________________________

Date of Injury ________ / ________ / ________

ICD9 Code(s)____________ ____________ ____________

Fx Gap: ____________mm ☐ less than 1cm

Comorbidities that apply (Check any applicalble):

☐ Alcohol use ☐ Diabetes ☐ Obesity
☐ Osteoporosis ☐ Tobacco use ☐ Arthritis
☐ AVN ☐ Comminuted fracture ☐ Osteomyelitis
☐ Advanced Age ☐ History of smoking ☐ Vascular disease
☐ Renal Disease ☐ Long term steroid use ☐ NSAIDS
☐ Other ________________________________

____

____

Location

☐ Prox ☐ Mid ☐ Distal
☐ Left ☐ Right ☐ Bilateral

Type

☐ Open
☐ Closed

Bone Site

☐ Tibia ☐ Medial Malleolus ☐ Lateral Malleolus
☐ Fibula ☐ Jones Fracture
☐ Tibia / Fibula ☐ Metacarpal 1 2 3 4 5
☐ Femur ☐ Metatarsal 1 2 3 4 5
☐ Ulna ☐ Phalanges (finger) 1 2 3 4 5
☐ Humerus ☐ Phalanges (toe) 1 2 3 4 5
☐ Radius ☐ Scaphoid
☐ Clavicle ☐ Other ____________

Prior Procedure(s) **Date(s)** ____________

☐ Osteotomy ☐ Bone Graft ☐ Debridement
☐ Internal Fixation ☐ Screws ☐ Plate
☐ IM Rod ☐ Wire ☐ External Fixation (current [ ])
☐ Cast (current [ ]) ☐ Fixator Removal
☐ Other ________________________________

OL1000 Bone Growth Stimulator "CMF 30-Minute Per Day Treatment"

PLEASE READ AND SIGN BELOW: I understand the Food and Drug Administration has approved the OL1000 Bone Growth Stimulator (OL1000) for the noninvasive treatment of an established nonunion acquired secondary to trauma, excluding vertebrae and all flat bones. A nonunion is considered to be established when the fracture site shows no visibly progressive signs of healing. I acknowledge that DJO, LLC, has not promoted the OL1000 to me for any other use or otherwise encouraged me to order it for any other use. I specifically desire to order the OL1000, which is only available directly from DJO, LLC, so that I may treat the patient in question according to my informed medical judgement. By my signature below, I am prescribing the bone growth stimulator device listed above. In my judgement, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

X Prescriber's Signature **Date**

DISPENSE AS WRITTEN
(no substitutions without authorization from prescribing individual)
Please retain a copy for your records

SALES REPRESENTATIVE NAME / TITLE (PRINT) SIGNATURE REPORTING CLINIC # (REQUIRED) DATE

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