CMF SPINALOGIC®

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

☐ Degenerative Disc Disease
☐ Internal Disk Disruption
☐ Herniated Nucleus Pulposus
☐ Lumbr Instability
☐ Low Back Pain
☐ Other _____

☐ Scoliosis
☐ Spondylosis
☐ Spondylolisthesis / Grade_____
☐ Spinal Stenosis
☐ Radiculopathy

_____

ICD9 Code(s) _____ _____ _____

Planned Procedure:

Date _____/ _____ / _____

Fusion Surgery _____ **to** _____

Other _____

Prior Procedure(s)	Date	Levels
☐ Fusion Surgery	_____/ _____/ _____	_____ to _____
☐ Discectomy	_____/ _____/ _____	_____ to _____
☐ Laminectomy	_____/ _____/ _____	_____ to _____
☐ Other	_____/ _____/ _____	_____ to _____

Comorbidities that apply (Check any applicalble):

☐ Multi-Level Fusion
☐ Mixed Graft
☐ Allograft
☐ Autograft
☐ Advanced Age
☐ Renal Disease
☐ Previous Back Surgery
☐ Other _____

☐ Obesity
☐ Tobacco use (_____ ppd)
☐ Failed Fusion
☐ Osteoporosis
☐ History of smoking
☐ Long term steroid use
☐ Stenosis

☐ Diabetes
☐ Arthritis
☐ Alcohol Use
☐ Spondylolisthesis
☐ Vascular disease
☐ NSAIDS

PLEASE READ AND SIGN BELOW: I understand the Food and Drug Administration has approved the SpinaLogic Bone Growth Stimulator (SpinaLogic) to use as an adjunct treatment to primary lumbar fusion surgery for one or two levels. I acknowledge that DJO, LLC, has not promoted SpinaLogic to me for any other use or otherwise encouraged me to order it for any other use. I specifically desire to order the SpinaLogic, 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.

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

X Prescriber's Signature **Date**

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

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