Rehabilicare®
Bringing your care home.

A Division of Compex Technologies, Inc.
P. O. Box 30244
Tampa, FL 33630-3244
(800) 343-0488
Corporate Fax: 1-800-272-6458

OL 1000
Bone Growth Stimulator
Rx-LMN

PATIENT NAME _____ SSN _____

DOB _____ PHONE _____

ICD9 CODE(S) _____ INJURY DATE ___/___/___ SURGERY DATE ___/___/___

OL 1000 Bone Growth Stimulator "CMF 30-Minute Per Day Treatment" Size: ☐Sm ☐Med ☐SC2 ☐SC3 ☐SC4

PRIMARY DIAGNOSIS:
☐ Nonunion ☐ Other _____

LOCATION:
☐ Prox ☐ Mid ☐ Distal ☐ Open
☐ Left ☐ Right ☐ Bilateral ☐ Closed

BONE SITE:
☐ Tibia ☐ Tibia/Fibula ☐ Radius ☐ Femur
☐ Fibula ☐ Ulna ☐ Clavicle ☐ Humerus
☐ Metatarsal 1 2 3 4 5 ☐ Metacarpal 1 2 3 4 5
☐ Other _____

PRIOR PROCEDURE(S): Date(s) _____
☐ Osteotomy ☐ Bone Graft ☐ Debridement ☐ Cast (Current[ ])
☐ Internal Fixation ☐ Screws ☐ Plate ☐ Fixator Removal
☐ IM Rod ☐ Wire ☐ External Fixation Cast (Current[ ])
☐ Other _____

CHECK ALL THAT APPLY:
☐ Tobacco use
☐ Alcohol use
☐ Osteoporosis
☐ Diabetes
☐ Comminuted Fracture
☐ Obesity
☐ Arthritis
☐ AVN
☐ Osteomylitis
☐ Other
_____
_____

DMERC-CMN PHYSICIAN NOTIFICATION - TO BE COMPLETED BY THE ORDERING PHYSICIAN ONLY

- A DMERC-CMN form is required to be completed by the ordering physician for each osteogenesis stimulator for Medicare beneficiary". For purposes of answering question 6a on the Certificate of Medical Necessity (CMN), a fracture nonunion is considered to exist only when a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis simulator, separated by a minimum of 90 days and each including multiple views of the fracture site, have been interpreted by a physician in writing as showing that there has been *no clinically significant* evidence of fracture healing between the two sets of radiographs. If this definition of nonunion is not met, question 6a must be answered No.

CONFIRMATION OF PHYSICIAN INTERPRETATION FOR LONG BONE NONUNION

- Have a minimum of two sets of multiple view radiographs been taken of the fracture site at least 90 days apart?
  ☐YES ☐NO

Date of first x-ray ___/___/___ Date of most recent x-ray ___/___/___

- Is there evidence of clinically significant healing between the two sets of radiographs?
  ☐YES ☐NO

PLEASE READ AND SIGN BELOW: I understand the Food and Drug Administration has approved the OL 1000 Bone Growth Stimulator (OL 1000) for the noninvasive treatment of a established nonunion acquired secondary to trauma, excluding vertebrae and flat bones. A nonunion is considered to be established when the fracture site shows no visibly progressive signs of healing. I acknowledge that Rehabilicare, has not promoted the OL 1000 to me for any other use to otherwise encouraged me to order it for any other use. I specifically desire to order the OL 1000, which is available from Rehabilicare, so that I may treat the patient in question according to my informed medical judgment.

☐ DISPENSE AS WRITTEN, NO SUBSTITUTIONS

X _____
PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S OFFICE CONTACT UPIN# PHONE

REPRESENTATIVE NAME

PLEASE RETAIN A COPY FOR YOUR RECORDS