CORFLEX®

Lace Align™ Spine

℞ Prescription Form

PATIENT NAME ______________________

DATE OF BIRTH ______________________

PATIENT PHONE ______________________

ICD-10 CODE ______________________

DIAGNOSIS ______________________

PHYSICIAN NAME ______________________

PHYSICIAN NPI # ______________________

FACILITY NAME ______________________

ADDRESS ______________________

____

CITY ______________________

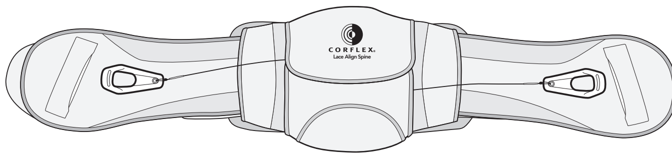
STATE ______________ ZIP ______________

OFFICE PHONE ______________________

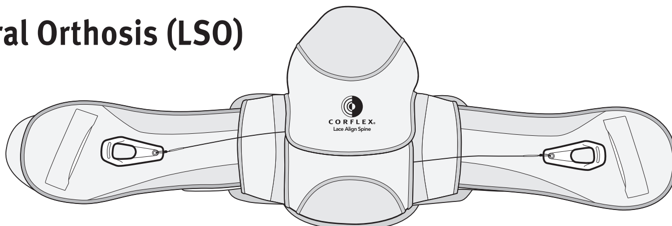
OFFICE FAX ______________________

Prescribed Product

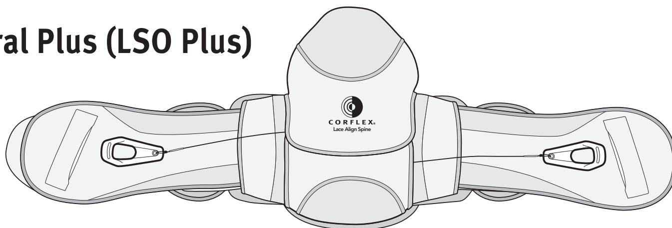
☐ **Lace Align**
Lumbar Orthosis (LO)
L0627/L0642



☐ **Lace Align**
Lumbosacral Orthosis (LSO)
L0631/L0648



☐ **Lace Align**
Lumbosacral Plus (LSO Plus)
L0637/L0650



INDICATIONS RELATING TO MEDICAL NECESSITY

☐ To reduce pain by restricting mobility of the trunk

☐ To facilitate healing following an injury to the spine or related soft tissues

☐ To otherwise support weak spinal muscles and/or deformed spine

☐ To facilitate healing following a surgical procedure on the spine or related soft tissue

Date of Procedure ______________

Description ______________

ADDITIONAL COMMENTS

It is my expert opinion that the product indicated for the above-named patient is medically reasonable and necessary to facilitate management of this patient's diagnosis. Please dispense as written.

PHYSICIAN/PROVIDER SIGNATURE ______________________ DATE ______________
(WITH CREDENTIALS)

Dispense as Written. No Substitutions.

1191/05-16