

Physician's Prescription for Offloading Spinal Orthotic

Physician Information

Physician's Name *(include M.D., DO, DC)*

Physician's address *(number and street)*

Physician's address *(city, state and ZIP code)*

Physician's phone number *(include area code)*

Patient Information

Patient's Name

Patient's Date of Birth

Patient's address *(number and street)*

Patient's address *(include city, state and ZIP code)*

Patient's phone *(include area code)*

Prescription Date

Rx: One Each Custom Fit LumboSacralOffloader
to be used on an "as-needed" or prn basis.

Dispense as written-No Substitutions

Physician's Signature