

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Referral Facility: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Referral Phone: \_\_\_\_\_ Referral Fax: \_\_\_\_\_

### DX/ICD 10

- |  |  |              |
|--|--|--------------|
| <input type="checkbox"/> Ulcer Lower Leg L97.9         | <input type="checkbox"/> Amputation Midfoot S98.3        | Other: _____ |
| <input type="checkbox"/> Ulcer Ankle L97.3             | <input type="checkbox"/> Amputation Foot/ankle S98.9     | _____        |
| <input type="checkbox"/> Ulcer Heel/midfoot L97.4      | <input type="checkbox"/> Amputation Partial Foot S98.921 | _____        |
| <input type="checkbox"/> Ulcer Unsp Part Of Foot L97.5 | <input type="checkbox"/> Amputation Foot S98.9           | _____        |
| <input type="checkbox"/> Amputation Great Toe S98.1    | <input type="checkbox"/> Amputation Ankle S98.01         | _____        |
| <input type="checkbox"/> Amputation Lessor Toe S98.13  | <input type="checkbox"/> Diabetes Mellitus 0800-E08.9    | _____        |

### WOUND ASSESSMENT

Wound Size in cm: L \_\_\_\_\_ x W \_\_\_\_\_ x D \_\_\_\_\_

Wound Location:  L  R \_\_\_\_\_

#### PROSTHETICS

- <sup>L R</sup> New Amputee Consultation
- Existing Prosthetic Device Evaluation 99243
- Symes Prosthesis L5050
- Partial Foot Prosthesis L5000
- Partial Foot Prosthesis with Integrated Carbon Dynamic AFO L5020
- Tibial Tubercle Height
- Post Op Prosthesis (Above Knee) L5410
- Post Op Prosthesis (Below Knee) L5430
- Below Knee Prosthesis L5301
- Above Knee Prosthesis L5321

Additional Notes

#### COMPRESSION

##### Products

- <sup>L R</sup> Dual Layer A6531 (X 2 PR)
- Single Layer A6531 (X 2 PR)
- Compression Wraps A6545 (X2 PR)
- Other: \_\_\_\_\_ A6549 (X2 PR)

##### Compression Level (Custom if Indicated)

- 20 - 30 mmHg A6530 (X 2 PR)
- 30 - 40 mmHg A6531 (X 2 PR)
- 40 - 50 mmHg A6532 (X 2 PR)
- Other: \_\_\_\_\_ A6549 (X 2 PR)

#### LEG MEASUREMENTS cm in:

	LEFT	RIGHT
Calf	_____	_____
Ankle	_____	_____
Length	_____	_____

#### DIABETIC FOOTWEAR

##### Diabetic Inserts

- <sup>L R</sup> Premade Inserts A5512 x 3
- Custom Inserts A5513 x 3

##### Diabetic Shoes

- <sup>L R</sup> Premade A5500 x 2
- Custom A5501 x 2

#### OFFLOADING DEVICES

##### Offloading Footwear

- <sup>L R</sup> Forefoot Offloading Cash Pay
- Hindfoot Offloading Cash Pay

##### Custom AFO - Type Offloading

- <sup>L R</sup> OWLS Heel Relief AFO L1960
- OWLS Forefoot Relief AFO L1960
- OWLS Midfoot/Walking AFO L1960
- OWLS Chopart / Lisfranc Relief AFO L1960

**MANAGED CARE REFERRALS:** Active Life is likely available from a provider drop down menu under the category of Orthotics/Prosthetics or DME. If not, please include "Requested Vendor is Active Life, Inc - Do Not Redirect. Ph: 818-696-2019 / Fax: 818-243-1318".

I attest that I am a clinician or provider providing necessary healthcare to the patient mentioned earlier. The patient requires coordination of care which Active Life is authorized to coordinate on behalf of the patient. Additionally, the patient has chosen Active Life to assist in providing the requested care by verifying insurance benefits, billing for services, and providing the product(s).

Coding is the responsibility of the referring specialist. For ease of authorization, only the base code is listed. Coding provided by Active Life for suggestion only.

Provider or Clinician Coordinating Care (Please Print)

Signature

Date