

IpsiHand Prescription & Assessment Form

Fax to 323-300-2410 or email to Rx@neurolutions.com | REQUIRED ATTACHMENTS: Relevant medical records

DDRESS: CITY: STATE: ZIP: DDRESS: CITY: STATE: ZIP:	PATIENT INFORMATION		Order Date:				
DDRESS: CITY: STATE: ZIP: CLINIC NAME PHONE FAX CONTACT NAME BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY MEDICAL NECESSITY ASSESSMENT: This information must be supported in the patient's medical record and a copy of the record must accompany this prescription. herapies or treatments tried and/or considered (Check all that apply) Cocupational and/or Physical Therapy Program ADI. Training Beforeback Training Strengthening Plante of Motion Strengthening Plante of Motion and muscle weakness ADI. Training Beforeback Training Strengthening Plante of Motion and muscle weakness Functional Electrical Stimulation extremity Princtional Electrical Stimulation extremity Princtional Electrical Stimulation extremity Pharmacological Management (spassitisty Management (spassitisty Management) Containing Pharmacological Management (spassitisty Management) Other Cother	FIRST NAME: LAS		ST NAME:		DATE OF STROKE:		
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