Zymonetics Treatment Plan

Scan & Email completed forms for Reimbursement to info@zymonetics.com

PATIENT PERSONAL INFORMATION:

Mr ☐ Mrs ☐ Ms ☐ Miss ☐

_____(___)_____(___)_____

First Name Ml Last Name Preferred Phone# Alternative Phone#

_____

Address City Province PC Email Address

_____

SIN# (optional) Sex:(M/F) DOB: (mm/dd/yyyy) Injury Date: (mm/dd/yyyy)

_____

Injury Site/Bone Type Surgery Date

_____

Co-morbidities Diagnosis Code(s) (ICD-9)

PHYSICIAN INFORMATION: License #_____Specialty_____

_____(___)_____(___)_____

First Name Initial Last Name Office Phone Fax

_____

Address City Province PC Email Address

Physician Signature X_____ Date: _____

☐ DO ☐ MD ☐ DPM ☐ DC

Device being prescribed:_____

DEEMED MEDICAL NECESSITY FOR THE FOLLOWING

☐ **MSK:** ☐ Spine ☐ Peripheral joint or soft tissue ☐ Trauma ☐ Arthritis ☐ Sports Medicine

☐ **Diabetes** - Type 1 Type 2

☐ **Osteoporosis**

☐ **General Physiatry**: ☐ Mobility ☐ Falls ☐ Disability Issues ☐ Chronic issues

☐ **Other**: _____

DIAGNOSIS: (Check/write all that apply)

☐ Osteoporosis

☐ Osteoarthritis /Inflammatory Arthritis

☐ Acute / Chronic Spine Pain

☐ Post-Trauma

☐ Peripheral Nerve Problem / Radiculopathy

☐ Failed Arthroplasty / Surgery

Other:_____

Brief Clinical History: _____

_____

_____

Please state your specific clinical question._____

_____

To assist in timely and accurate care, please include all of the following that apply

CURRENT MEDICATION LIST, INVESTIGATIONS TO-DATE AND CONSULT NOTES FROM OTHER SPECIALISTS- for e.g.

- X-Rays - plain, CT, MRI, Bone Scan. Diagnostic EMG
- Other consults - Neurology, Orthopedics, Rheumatology, Neurosurgery and Psychiatry

(Reports to Follow)	**YES**	**NO**
Has the list of current medications been included with this prescription?	☐	☐
Have the list of investigations & consults been included with this prescription?	☐	☐

Signature of Physician **X**_____Date: _____

INSURER'S INFORMATION (Complete if different than patient)

First Name Initial Last Name (___)_____ Preferred Phone# (___)_____ Alternative Phone#

Address City Province PC Email Address

SIN# Sex:(M/F) DOB: (mm/dd/yyyy) Relationship to Patient

Name of Employer

PRIMARY INSURANCE COVERAGE

Insurance Company (___)_____ Phone Number (___)_____ Fax Number

Address City Province PC Email Address

Group Policy* ID# Claim #

SECONDARY INSURANCE COVERAGE

Insurance Company (___)_____ Phone Number (___)_____ Fax Number

Address City Province PC Email Address

Group Policy* ID# Claim #

For Zymonetics use only

REPRESENTATIVE INFORMATION

VERIFIED _____

Clinical Rep _____

Rep Phone # _____

Zymonetics Rep _____

SHIPPING INFORMATION

Name _____

Address _____

City _____

Province _____

PS _____

Scan & Email completed forms for Reimbursement to: info@zymonetics.com