

Phone:(888)330-2289

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Email: cindy@motherapeutics.com

Name: _____ Date: _____
 Diagnosis: _____ DOB _____
 Address: _____
 Phone Number: _____ Email: _____

Please check as indicated:

- | | |
|--|--|
| <input type="checkbox"/> Examination and treatment | <input type="checkbox"/> To facilitate healing post soft tissue or spine injury |
| <input type="checkbox"/> To support weak spinal muscles | <input type="checkbox"/> To facilitate healing post surgical procedure on spine or related soft tissue |
| <input type="checkbox"/> To reduce pain by restricting mobility of the trunk | <input type="checkbox"/> Balance |
| <input type="checkbox"/> To support deformed spine | |

ICD-10 code: _____

Physician Signature: _____

National Provider Number: _____

BalanceWear®-Trained Clinician Fills Out Below

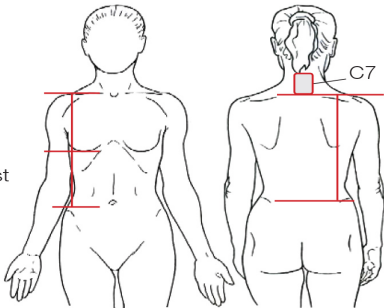
- | | |
|---|---|
| <input type="checkbox"/> OW200 BalanceWear Custom LSO | <input type="checkbox"/> BW450 BalanceWear Breeze™ |
| <input type="checkbox"/> BW300 BalanceWear Classic | <input type="checkbox"/> OW226 BalanceWear® Lumbar Support 6" |
| <input type="checkbox"/> BW350 BalanceWear LightWeight™ | <input type="checkbox"/> OW228 BalanceWear® Lumbar Support 8" |

Weights Needed: 1/2 # _____ 1/4 # _____ 1/8# _____ 1/16# _____

Weight Placement

F. Draw the final weight amount and placement on the body diagram:

<input type="checkbox"/>	Measurement from top of shoulder to bottom of breast
<input type="checkbox"/>	Measurement from top of shoulder to 1 inch below waist
<input type="checkbox"/>	Measurement from top of shoulder to L5S
<input type="checkbox"/>	Measurement from C7 to L5S1
<input type="checkbox"/>	Waist measurement



Clinician Printed Signature: _____ **Phone #** _____