

CLINICAL PROGRESS NOTE

Patient presents today with a back condition and describes the pain as:

- Constant Sharp Dull Aching Worsening Throbbing Burning Other: _____

On a pain scale, patient rates the pain: _____ / 10

Aggravating Factors:

- Walking Standing Bending Twisting Sitting Other: _____

Patient also has a prior history of:

- History of Back Pain Previous Back Surgery, Hx of Scoliosis Disc Pathology Other: _____

Failed Conservative Treatments:

- OTC Medication. For how long? _____ Home Exercises. For how long? _____
 Ice / Heat Application. For how long? _____ Stretching. For how long? _____
 OTC Supports. For how long? _____ Other: _____

Examination:

- MUSCLE TONE Negative Positive Not Tested
ALIGNMENT Negative Positive Not Tested
NEUROLOGIC SYMPTOMS: _____ Negative Positive Not Tested
SPASMS Negative Positive Not Tested
STRAIGHT LEG TEST Negative Positive Not Tested
OTHER: _____ Negative Positive

Evaluation of the patient reveals:

- Lordosis / Deforming Spinal Diseases Compromised Cognitive / Physical Ability Short Stature / Torso Traumatic Symphysis Pubis Diastasis
 Sagittal Plane Imbalance Lumbago Radiculopathy Scoliosis
 Waist to Hip Ratio Disparity Coronal Plane Imbalance Sciatica Meralgia Paresthetica
 Other: _____ Round Ligament Pain

Prescribing a custom-fit LSO to:

- Reduce pain by restricting mobility of the trunk.
 To support weak spinal muscles and / or a deformed spine.
 To unload / reduce pressure on the spine's joints, discs, and muscle to lessen muscle tension.
 To prevent / restrict painful movements and postures during activities that may exacerbate their back pain or increase the likelihood of injuring themselves during daily activities.
 To facilitate healing following a surgical procedure on the spine or related soft tissue.

A custom-fit brace / LSO is medically necessary for the following criteria:

- Waist to hip ratio / disparity OTC, off the shelf, or other medical supports cannot appropriately and safely provide the necessary support or fit disparities in the constantly changing body habitus, waist-to-hip ratios without customized adjustments.
 Pendulous abdomen The anterior and posterior panels can be safely worn throughout treatment and are required to reduce deformity, motion and stabilize core muscle dysfunction.
 Obesity / BMI Multi-vertebral level injury / surgery A custom-fit LSO with anterior and posterior panels provides the necessary biomechanical support needed for the patient's back condition.
 Accommodate post-surgical dressings Avoid harmful medications The patient has had clear counseling and instruction on using the brace and panels.
 Avoid harmful imaging tests Hyper / hypo-lordosis Hyper-kyphosis The goal of the LSO treatment is to stabilize the patient's core, preventing further injury and improve their functional activity level.
 Scoliosis Spinal deformity
 Short stature / torso Compromised cognitive / physical activity
 Other: _____

ADDITIONAL NOTES:

Attestation and Signature / Date

I certify that I am the treating provider identified on this form and that the patient named above is a patient in my office. I certify that the medical information on this form is true, accurate and complete, to the best of my knowledge. I have prescribed the above listed item as an essential part of my treatment plan for this patient. This item is not being prescribed as a comfort or convenience item, but is reasonable and necessary for the proper treatment of my patient's condition. This item will or is reasonably expected to assist the patient in achieving and maintaining maximum functional capacity in performing daily activities.

Provider Signature _____
Provider Name _____

Date _____
NPI# _____