

# Letter of Medical Necessity

Date:

To:

**Attached please find a detailed assessment, medical justification and equipment recommendation for:**

Patient/Client:

Age:  years old

Gender:  Male  Female

Weight:  lbs.

Height:  in.

Diagnosis:

Specify Other:

**Physical/Medical Condition**

**This individual's current medical diagnosis and clinical presentation include:**

Medical History of:

<u>Range of Motion:</u>	Upper Extremities	Good	Fair	Poor
	Lower Extremities	Good	Fair	Poor

<u>Muscle Tone:</u>	Upper Extremities	Good	Fair	Poor
	Lower Extremities	Good	Fair	Poor

<u>Bowel and Bladder Control:</u>	Bowel	Good	Fair	Poor
	Bladder	Good	Fair	Poor

<u>Cardiovascular:</u>	Good	Fair	Poor
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Posture:

Pelvis	Posterior Tilt	Anterior Tilt	Pelvic Obliquity		Pelvic Rotation		
Trunk	Kyphosis	Lordosis	Scoliosis	Rotation			
Head/Neck	Hyperextension	Hyperflexation	Decreased Tone	Floppy	Lordosis	Tilt	Rotation
Lower Extremities	Abduction	Adduction	Windswept				
Upper Extremities	Protracted Scapulae		Retracted Scapulae				
Head Control	Good	Fair	Poor				
Balance	Good	Fair	Poor				
Functional Status	Ambulate	Non-Ambulate	Lift	No Lift			

Current Therapy

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Current Equipment

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**Patient/Client is currently experiencing the following problems with this equipment:**

Outgrown	Disrepair	Insufficient for Clients Needs
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Other Problems:

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Therapy Goals

- 1
- 2
- 3
- 4


**Recommended Equipment:**

**Broda Chair, Model:**

Contracture	Shower	Glider	785	MID	Pedal	MID
Other:						

Accessories:

Lap Belt	Thigh Belt	Tray
Mag Wheels	Hip Pads	
Other:		

**The following outcomes are expected with this equipment:**

- 1
- 2
- 3
- 4


Additional Comments

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Therapist's Name:

Facility:

Address:

City:

Phone:


\_\_\_\_\_  
Signature

Doctor's Name:

Address:

City:

Phone:


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Signature