Bio-Tech
Prosthetics and Orthotics

Thank you so much for choosing Bio-Tech to be part of your prosthetic rehabilitation plan. This form allows us obtain the information required to create your prosthetic plan and to obtain funding from Medicare and other insurance companies.

Medicare, as well as many other insurance companies, require you to discuss the information in this form with your physician during a face-to-face encounter. Depending on your needs, we may refer you back to your physician for this reason. If this is the case, we will provide you with a letter to present to your physician, so that he or she will have the tools needed to include all necessary information in the dictation/progress notes during your face-to-face visit with the physician.

PATIENT INFORMATION

Patient First Name_____Last_____MI_____

DOB_____/_____/_____ Gender ☐ Male ☐ Female SSN_____/_____/_____

Vocational Status ☐ Retired ☐ Employed ☐ Unemployed ☐ Disability ☐ Student

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Preferred Language ☐ English ☐ Spanish

Email_____@_____.com

Phone _____(Home) _____(Cell) _____(Work)

Address_____City_____ST_____Zip_____

By providing your contact information, you allow Bio-tech to contact you via mail, phone, and/or email. If you would like to limit our method of contact, please specify here_____

Emergency Contact_____Phone_____

Insurance Company_____ID#_____Group_____

If the primary subscriber is another adult, or if the patient is a minor, please provide the following information for the responsible party/primary subscriber:

Name_____DOB_____/_____/_____☐ Spouse ☐ Parent ☐ Other

Only complete this box if your care is related to a work comp case, auto injury, or other third party liability:

Employer (at time of injury)_____

Work Comp Company Handling Claim_____Phone_____

Claim#_____Adjuster/Case Manager_____

☐ Auto Accident, Injury Date_____/_____/_____

☐ I was injured and another person is legally responsible for my injury

PATIENT PORTION (continued) Patient Name_____ _____/_____/_____

Primary Care Physician_____ Phone_____

Surgeon_____ Phone_____

Physical/Occupational Therapist_____ Phone_____

Wound Care_____ Phone_____

If Diabetic, Managing Physician_____ Phone_____

1 **Amputation Date**_____/_____/_____

☐ Partial Foot ☐ Left ☐ Right ☐ Below Elbow ☐ Left ☐ Right

☐ Below Knee ☐ Left ☐ Right ☐ Above Elbow ☐ Left ☐ Right

☐ Above Knee ☐ Left ☐ Right ☐ Other_____ ☐ Left ☐ Right

Cause ☐ Diabetes ☐ Cancer ☐ Trauma (please explain)_____

☐ Vascular Disease ☐ Birth ☐ Other_____

2 **Have you previously used a prosthetic limb?** ☐ Yes ☐ No

If YES,

When did you receive your current (or last) prosthetic limb? _____/_____/_____

Who fabricated the prosthetlic limb for you?_____

Would you consider yourself a successful prosthetic user? ☐ Yes ☐ No

Please check any of the health conditions below that apply to you.

☐ Arthritis	☐ Gout	☐ Depression	☐ Cerebral Palsy
☐ Osteoporosis	☐ Stroke	☐ Anxiety	☐ Post-Polio
☐ Fibromyalgia	☐ Chronic Pain	☐ Memory Loss	☐ Immune Compromised
☐ Joint Pain	☐ Diabetes	☐ Cancer	☐ Communicable Disease
☐ Muscle Pain	☐ Parkinson's Disease	☐ MRSA	☐ Vascular Disease
☐ Wound Healing Delay	☐ MS	☐ Pregnancy	☐ Previous Heart Attack
☐ Respiratory Disease	☐ Seizures	☐ Ulcers/Skin Breakdown	☐ Skin Allergies_____

6 How would you rate your motivation for a successful orthotic or prosthetic rehabilitation?

Not Motivated ⟷ Very Motivated

1 2 3 4 5

Patient Signature

By signing below, you verify that you have provided this information accurately and to the best of your knowledge. You also understand that Bio-Tech may obtain photographs and/or video of you for clinical purposes.

Patient/Guardian Signature_____ Date_____/_____/_____

Patient Name_____ ____/____/_____

This box for clinical staff only

3-4 **Recommended Device(s):**

☐ Socket ☐ Volume Loss _____ ☐ Volume Increase _____ ☐ Irreparable Damage ☐ Other_____

☐ Knee ☐ Irreparable Damage ☐ Activity Level Increase ☐ Activity Level Decrease ☐ Other_____

☐ Foot ☐ Irreparable Damage ☐ Activity Level Increase ☐ Activity Level Decrease ☐ Other_____

☐ Initial Prosthesis

5 **Current K-Level**

☐ 1 Basic/household ambulation

☐ 2 Limited community ambulator

☐ 3 Extremely active/walks at variable speeds/uneven terrain/extreme home/work needs

Home/work needs_____

☐ 4 Athlete/child

Home/work/needs_____

Potential K-Level

☐ 1 Basic/household ambulation

☐ 2 Limited community ambulator

☐ 3 Extremely active/walks at variable speeds/uneven terrain/extreme home/work needs

Home/work needs_____

☐ 4 Athlete/child

Home/work/needs_____

7 **Treatment Timeline**

☐ The patient should be able to achieve successful rehabilitative results once the recommended device(s) is provided

☐ The patient should be able to achieve successful rehabilitative results once:_____

_____

Staff Reminder:

- For **MEDICARE** and **United Healthcare**: practitioners must complete and provide form to PCC during patient visit
  - For K3 components, an unsigned formal functional assessment must also be completed for physician sign-off
- All numbered sections need to be addressed in detail in our dictation/progress notes.
- Numbered sections relate to letter to patient's physician letter
- PCC must scan in completed form under patient information