

JAS

Joint Active Systems, Inc
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 877.406.4872

SPANISH INSTRUCTIONS

ORDER DATE:
JAS REP:

PATIENT NAME (LAST, FIRST) <input type="checkbox"/> M <input type="checkbox"/> F		HOME PHONE		CELL PHONE		GUARANTOR (LAST, FIRST)		PHONE		S.S.#			
ADDRESS			CITY	STATE	ZIP	D.O.B.	ADDRESS		CITY	STATE	ZIP	REL. TO PATIENT	
EMPLOYER			WORK PHONE		S.S.#		EMPLOYER			WORK PHONE		D.O.B	
PRIMARY INS (<input type="checkbox"/> W/C <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER)				PHONE				SECONDARY INSURANCE			PHONE		
ADDRESS			CITY		STATE	ZIP	ADDRESS			CITY	STATE	ZIP	
POLICY#		GROUP#		CLAIM REP		EXT	POLICY#		GROUP#		CLAIM REP		EXT
PRESCRIBING PHYSICIAN					NATIONAL PROVIDER ID #			FULL NAME - PT / OT			CLINIC		
ADDRESS			CITY		STATE	ZIP	CLINIC ADDRESS			CITY	STATE	ZIP	
PHONE			FAX				PHONE		FAX		EMAIL		
PRIMARY DIAGNOSIS				INJURY DATE / ONSET			SPECIAL INSTRUCTIONS						
SECONDARY DIAGNOSIS				SURGERY DATE			SHIP TO ADDRESS <input type="checkbox"/> CLINIC <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OTHER						

LOCATION SIDE <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT		MEASUREMENTS (IN INCHES) (TAKE ALL CIRCUMFERENCE MEASUREMENTS AT WIDEST PORTION OF BODYPART)									
RENTAL DEVICES <input type="checkbox"/> ELBOW <input type="checkbox"/> PRO/SUP <input type="checkbox"/> WRIST <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> SHOULDER <input type="checkbox"/> FLOOR MOUNT <input type="checkbox"/> PORTABLE		ELBOW / EZ ELBOW: <u>Circumference:</u> Upper Arm ____ Forearm ____ <u>Length:</u> Crease of Axilla to the Tip of Olecranon (90° sh abd) ____ Lateral Epicondyle – Ulna Styloid ____									
		PRO / SUP / EZ PRO/SUP: <u>Circumference:</u> Upper Arm ____ <u>Length:</u> Crease of Axilla to the Tip of Olecranon (90° sh abd) ____ Lateral Epicondyle – Ulna Styloid ____									
		WRIST / EZ WRIST: <u>Circumference:</u> Forearm ____ <u>Length:</u> Lateral Epicondyle – Ulna Styloid ____									
		FINGER: <u>Length:</u> Tip of Finger to Center of MP Joint ____ <u>Width:</u> Back of hand across MP Joints ____									
PURCHASE DEVICES <input type="checkbox"/> EZ ELBOW <input type="checkbox"/> EZ KNEE EXT <input type="checkbox"/> EZ WRIST <input type="checkbox"/> EZ KNEE FLEX <input type="checkbox"/> FINGER <input type="checkbox"/> EZ PRO/SUP <input type="checkbox"/> EZ TOE SHOE SIZE ____		KNEE / EZ KNEE: <u>Circumference:</u> Upper Thigh 1½ distal to Perineum ____ 4” proximal to Mid-patella/popliteal Crease ____ Largest point of the calf ____ 2 ½ “ proximal to Lateral Malleolus ____ <u>Length:</u> Perineum – Popliteal Crease ____ 3” distal to Mid-patella-Lateral Malleolus ____ Largest point of the calf – Lateral Malleolus ____									
		ANKLE: <u>Circumference:</u> Calf ____ <u>Length:</u> Med. Knee Jt Line—Med Malleolus ____ Shoe Size ____									
		ROM: FLEXION ____ EXTENSION ____ PRONATION ____ SUPINATION ____ DORSI-FLEXION ____ PLANTAR-FLEXION ____									