



PATIENT REFERRAL FORM

Medical Art Prosthetics Clinics and Anaplastologists

Patient Referral and Medical Records Receiving Center – Madison, Wisconsin

Appointments: (877) 242-7951 Fax: (608) 893-6404  www.medicalartprosthetics.com

 **Patient Information**

First Name: _____ M.I.: _____ Last Name: _____

Gender: M F DOB: _____ Phone: _____

 **Diagnosis**

ICD-10 Code: _____ Diagnosis Description: _____



Prosthesis Requested

Finger Prosthesis — (durable patient-specific prosthetic finger to restore digit length and passive function for activities of daily living, occupation, etc.) Left Hand Digits Affected: 1 2 3 4 5 Right Hand Digits Affected: 1 2 3 4 5

Partial Hand Prosthesis — (durable glove-style hand prosthesis to restore and retain 1 or more digits and provide passive function for activities of daily living, occupation, etc.) Left or Right

Full Hand Prosthesis — (durable silicone prosthesis to restore and retain complete hand and passive hand function for activities of daily living, occupation, etc.) Left or Right

Toe Prosthesis — L5999 - (durable patient specific silicone prosthesis to restore digit length and maintain toe alignment and foot stability) Left Foot Digits Affected: 1 2 3 4 5 Right Foot Digits Affected: 1 2 3 4 5

Partial Foot Prosthesis — L5999 - (lifelike durable silicone forefoot prosthesis to restore 1 or more toes and provide stability for health of foot and patient safety)

Complete Foot Prosthesis — L5999 (lifelike durable silicone prosthesis to restore toes 1-5 and provide stability for health of foot and patient safety)

Breast Prosthesis — L8035 (external, molded to patient chest wall, lifelike breast restoration with full detail matched to patient)

Other: _____

Comments/Details:



Referring Physician

Physician Name: _____ NPI #: _____

Practice Location: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____



FAX this completed form and supporting documentation to (608) 893-6404.