



Solutions for Daily Living

# LETTER OF MEDICAL NECESSITY

**IMPORTANT PRIVACY NOTICE:** *Columbia Medical does not sell, transfer, record or otherwise maintain any information that is entered in this Letter of Medical Necessity.*

**\*Required Items**

**\*To:**

**Date:**

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

### Patient Information

**\*Patient/Client:**

**\*Age:**

years old

**\*Gender:**  Male  Female

**Diagnosis Code:**

**Specify Other:**

**\*Weight:**

lbs.

**\*Height:**

in.

### Physical/Medical Condition

The individual's current medical diagnosis and clinical presentation include:

**\*Medical History of:**

### Range of Motion Description

**Upper Extremities:**  Good  Fair  Poor

**Lower Extremities:**  Good  Fair  Poor

### Muscle Tone and Spasticity Description

**Upper Extremities:**  Increased  Decreased  Fluctuating  Within functional limits

**Lower Extremities:**  Increased  Decreased  Fluctuating  Within functional limits

### Bowl and Bladder Control Description

**Bowl:**  Continent  Incontinent  Training

**Bladder:**  Continent  Incontinent  Training

### Cardiovascular Endurance Description

Good  Fair  Poor

### Posture Description

**Pelvis:**  Posterior Pelvic Tilt  Anterior Pelvic Tilt

Pelvic Obliquity  Pelvic Rotation

**Trunk:**  Kyphosis  Lordosis  Scoliosis  Rotation

**Posture Description (Continued...)**

- Head/Neck:**             Hyperextension       Hyperflexion       Decreased Tone  
 Floppy       Cerebral Lordosis       Lateral Tilt       Rotation
- Lower Extremities:**     Leg Abduction       Leg Adduction       Windswept
- Upper Extremities:**     Protracted Scapulae       Retracted Scapulae
- Head Control Description:**     Good                       Fair                       Poor
- Balance Description:**         Good                       Fair                       Poor
- Functional Status:**             Ambulate       Non-Ambulate       Wheelchair Dependent Transfer  
 Wheelchair Independent Transfer     Wheelchair Transfer with Assistance

**Current Therapy Program and Equipment**

\*Patient/Client's current therapy program at home and/or school includes the following:

Patient/Client is currently using the following equipment:

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

- Outgrown                       Disrepair                       Insufficient for Client's needs

Other Problems:

**\*Therapy Goals**

The functional goals for this patient/client include the following:

1.
2.
3.
4.



**Recommended Equipment**

Our recommendation is that the following Columbia Medical equipment be provided:

**\*Select a Columbia Product:**

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**1. Select an accessory:**

**2. Select an accessory:**

**3. Select an accessory:**

**4. Select an accessory:**


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

1.
2.
3.
4.

**\*The equipment should be used in accordance with the following therapy guidelines:**

1.
2.
3.
4.

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**Additional Comments:**

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**Signatures**

Therapist's Name: _____	License #: _____
Therapist's Signature: _____	Date: _____
Facility: _____	Dept: _____
Address: _____	City: _____ State: ____ Zip: _____
Phone: _____	Fax: _____

Doctor's Name: _____	License #: _____
Doctor's Signature: _____	Date: _____
Facility: _____	Dept: _____
Address: _____	City: _____ State: ____ Zip: _____
Phone: _____	Fax: _____