**Step 1: Fax/Email RX** **Step 2: Original Copy to Patient** **Step 3: Patient Call To Book Appt.**

*Walk-ins are accepted for some services such as cast removal/braces, compression socks, suture/staple removal, mobility aids.*

# Certificate of Medical Necessity/RX Treatment Plan

Get back to life, work & play. Faster

#108, 8708-155 Street NW
Edmonton, AB, T5R 1W2
**PH: 780-907-2082**
FX:780-466-0041
info@aoservices.ca
HRS: Mon - Fri (9am-5pm)
Closed Weekends/Holidays/Lunch 12pm-1pm

| PATIENT INFO | | | | PHYSICIAN INFO |
|---|---|---|---|---|
| First name: | ____ | Last Name: | ____ | Name: |
| DOB: | ____ | PH: | ____ | Specialty: |
| Address: | ____ | | | Email: |
| Email: | ____ | AHC#: | ____ | PH: |
| Insurer: | ____ | Policy#/ID#: | ____ | FX: |
| WCB Claim#: | ____ | MVC Claim#: | ____ | Next F/U date w/pt: |

## CAST CLINIC

Diagnoses: ____
Location of injury: ____
Date of injury: ____
Surgery Performed: ____
Date of surgery: ____
Date of last x-rays: ____
Acute & Stable: _____ Yes _____ No
Non-Union: _____ Yes _____ No

### Check all applicable services requested

___Cast or ___ Splint or ___Brace
___Cast off only ___Above elbow ___Thumb Spica
___Scaphoid ___Patellar Tendon Bearing
___Serial Casting ___AFO (Aircast/boot)
___Other: ___Forearm/BE
___First application ___Replacement Reason:_______

### Position and Modifications

___Neutral ___Position of comfort

Other:

___Removeable for showering/ROM ___Shower Cover
___Standard fiberglass
___Waterproof
___Weightbearing ___Non Weightbearing
___Bivalve ___Window

### Additional Instructions

## PHYSICIAN SIGNATURE

X:_____________________________________________

DATE:

## LIMB PRESERVATION CENTRE

Diagnoses: ____
Location of wound: ____
Date wound formed: ____
Surgery Performed: ____
Date of surgery: ____
ABI/TBI Testing Date: ____

*If ABI/TBI not done in last 3 months, check below to be performed in our clinic

### Check all applicable services requested

___Full Lower Leg Assessments and wound management
___ABI/TBI Testing Only ____ *(check to send results)*
___Diabetic Foot Screening
___Regular Diabetic/High Risk Foot Care
(*Strongly Recommended for all diabetics q.4-6 wks*)
___Neuromuscular Stimulation to improve lower leg circulation
___Compression Socks/Wraps mmHg:____
___Total Contact Casting (TCC)
___Suture/Staple Removal

Other:

### Additional Instructions

## MOBILITY AIDS/RENTALS/OTHER SERVICES

***Ideal 100% offloading is often achieved with the use of mobility aids in addition to Cast Clinic & Limb Preservation services.***

____# Weeks Required
____Knee Walker/Scooter
____Cane ___Iwalk Hands Free Knee Crutch
(*Pt.must be able to safely balance for 30 sec. on good foot to qualify)
____Walker ___2 wheel walker
____4 wheel walker/rollator
____Other:
____ **Referral to Physiotherapy/Rehab post treatment**

**Thank you for your kind referral. We look forward to serving your patient.**

*We also carry a wide variety of affordable products and supplies which compliment all our services to be purchased in person or online at www. aoservices.ca*