Basingers Pharmacy

2130 W Jefferson St. Joliet, IL 60435
815-725-1102

Rx and Letter of Medical Necessity

Patient Information **Insurance Information**

Name:	Date of Birth:
Height: Weight:	Phone Number:

Orthosis Prescribed:

❒ OTS Lumbar (L0642)	❒ Horizon 631 LSO (L0631)	❒ Active Posture TLSO (L0456)
❒ OTS LSO (L0650)	❒ Horizon 637 LSO (L0637)	❒ Aspen Therapy Collar (L0180)
❒ OTS TLSO (L0457)	❒ Horizon 456 TLSO (L0456)	❒ Peak Scoliosis System (L1005)

Medical Necessity for Spinal Orthosis:

____ Used to otherwise support weak spinal muscles or deformed spine

____ Used to facilitate healing following injury to the spine or related soft tissue

____ Used to reduce pain by restricting mobility of the trunk

____ Used to facilitate healing following a surgical procedure on the spine or related soft tissue

ICD10/DIAGNOSIS:_____

Date Ordered: _____ **Date Delivered:_____**

I, the undersigned, certify that the equipment indicated above is medically necessary for this patient's well being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition.

Physician Information

Signature:	Date:
Printed Name:	NPI Number:
Address:	City: State: Zip:
Phone Number:	Fax Number:

Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500)

Medication Transfer Sheet/Release of Responsibility

Name of Facility: _____

Name of Resident: _____

_____

Date of Release: Expected Date of Return:

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:

a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.

OR

b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR

c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: _____
Received by: _____ Date: _____ Time: _____
Signature of person returning unused medications: _____
Staff signature of count on return: _____ Date: _____ Time: _____