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:	**Reason(s) Knee Orthosis is Medically Necessary**	
❒ **L1851 OA Knee Brace**	❒ Varus / Valgus Instability	❒ Positive for ligament Laxity
❒ **L1833 ROM Knee Brace**	❒ Positive Anterior Drawer Test	❒ Positive for patellar instability
❒	❒ Positive Posterior Drawer Test	❒ Joint instability / laxity

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: __________