181 Chesterfield Business Pkwy, Chesterfield, MO 63005
Phone: (636) 536-5337
Send Self-Referrals to **neworders@gatewaymedical.net** or fax to: (636) 489-1564

Patient Medical Brace Interest Form

I am interest in getting a brace, and I completed this form/it was completed at my request. I give permission for Gateway Medical Equipment to contact the Medical Provider below to request a prescription for the recommended brace, as well as other necessary information such as insurance information and medical history. **If** my Medical Provider approves the recommended brace, I understand that I have the right to select and Durable Medical Equipment Provider, such as Gateway Medical Equipment, to provide the brace as prescribed by my Medical Provider.

Signature:____________________________________Date:________________________

Name:______________________________________
Date of Birth:__________________
Phone:_______________________
Insurance Provider:______________________________
Physician:_______________________________
Physician Phone:_____________________
Physician Fax:__________________
Physician Address:______________________________

Please select all that apply:

- ☐ Back Pain:
  - ☐ Lower
  - ☐ Upper
  - ☐ Both
- ☐ Foot Drop:
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Kyphosis
- ☐ Neck Pain
- ☐ Knee Pain:
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Hand Abnormality (arthritis, stroke, etc):
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Scoliosis
- ☐ Other:___________________________

Additional information/concerns:____
____
____