EXCYABIR HIP BRACE

Outcome-Based Technologies, LLC
T: (888) 740-5464
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www.EXCYABIR.com

PRESCRIPTION / DETAILED WRITTEN ORDER

Patient Name:_____ **DOB:**_____/_____/_____

ICD-10(s): **1)**_____ **2)**_____ **3)**_____

Order Date:
_____/_____/_____
REQUIRED

Location: *(please fill)*
Clinic Name:_____ Phone: (_____) _____-_____
Address: _____ Contact: _____

Rx **Prescription/Detailed Written Order** (quantity 1 unless otherwise indicated)

MUST SPECIFY: ☐ **RIGHT** ☐ **LEFT** ☐ **BI-LAT (qty 2)**

Surgical Info (if applicable): ☐ **SURGERY DELAYED**
Surgery Date: _____/_____/_____
Location: _____

☐ L1686 – EXCYABIR Hip Brace

DO NOT SUBSTITUTE

Includes TWO COLD/HOT gel packs

Common Configurations:

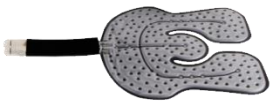
- ☐ **Hip OA**
  Abduction, compression and internally rotate; pressure on less affected parts of the hip joint.
- ☐ **FAI/Labral**
  Abduction & limit external rotation
- ☐ **Gluteus Medius/Minimus Repair**
  Abduction & limit external rotation
- ☐ **THA Anterior Approach**
  Abduction & limit external rotation
- ☐ **THA Superior/Posterior Approach**
  Abduction

Customize:

- ☐ Limit External Rotation / Limit Extension
- ☐ Limit Internal Rotation / Limit Flexion
- ☐ Hip Abduction / Compression
- ☐ ROM Hinge
- ☐ Extension Setting: _____
- ☐ Flexion Setting: _____

☐ E0218 – Cold Unit w/ Universal Pad

(recommended only for post-operative use)



Cold Therapy Use Instructions:

_____

_____

_____

X _____ *(provider signature, INK ONLY, NO STAMPS)*

X _____/_____/_____ *(prescribe date)*

I certify that the item(s) prescribed here within, are medically necessary and integral to this patient's plan of care and within accepted medical standards for this patient's medical condition.

Provider (please fill)**:**

Name:_____

NPI:_____

Questions?
Call or email us at the info below.
T: (888) 740-5464
info@excyabir.com

Fax To: (888) 388-3454
Please include patient demos and notes.

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