TRICARE PHYSICIAN'S ORDER

Today's Date: _____

Patient's Full Name: _____ **DOB:**_____

Patient's Address: _____

Sponsor's SSN or Patient Benefit #: _____ **Patient Ph # :**_____

Email Address: _____**Due Date:** _____

☐ **Postpartum Care System**
Sacroiliac Orthosis, Pelvic Sacral Support w/Straps Brace; which includes Abdominal Perineum Pelvic Floor Support. Triple Truss design with H2O pad for compression therapy and Genital Support

DIAGNOSIS	SIZING
☐ R10.2 Pelvic and perineal pain ☐ R10.30 Lower Abdominal, inguinal, groin pain ☐ 071.89 Other specified obstetric trauma (Diastasis Recti) ☐ M54.5 Acute or chronic pain in the lumbar or sacral regions ☐ M25.551/M25.552 Hip pain R/L ☐ S30.23 Contusion of vagina and vulva ☐ K42 Umbilical hernia O70 Perineal laceration during delivery: ☐ O70.0 First degree perineal laceration during delivery ☐ O70.1 Second degree perineal laceration during delivery ☐ O70.2 Third degree perineal laceration during delivery ☐ O70.3 Fourth degree perineal laceration during delivery ☐ O70.4 Anal sphincter tear complicating delivery, not associated with third degree laceration N81 Female genital prolapse: ☐ N81.2 Incomplete uterovaginal prolapse ☐ N81.3 Complete uterovaginal prolapse ☐ N81.4 Uterovaginal prolapse, unspecified N81.8 Other female genital prolapse: ☐ N81.83 Incompetence or weakening of rectovaginal tissue ☐ Other: _____	**How to measure for the postpartum care system?** Sized to fit the postpartum body and has over 6″ of adjustability to shrink with patient as they heal. When sizing, we recommend measuring below the belly and around the top of the patient's hip bone (Iliac Crest). Please state the patient measurement:_____ *Measure below the belly around the pelvis/hips.* XS S M L XL 2XL 3XL 4XL **Size** / **Fits Postpartum Size** XS — 29" to 34" (73cm to 87cm) S — 32" to 37" (82cm to 94cm) MED — 35" to 42" (94cm to 107cm) LG — 38" to 45" (97cm to 115cm) XL — 42" to 48" (107cm to 123cm) 2XL — 48" to 54" (122cm to 137cm) 3XL — 54" to 60" (137cm to 152cm) 4XL — 60" to 64" (152cm to 163cm)

Duration of Need: _____ **(example: Lifetime or 99 months)**

Physician's Name Printed: _____ **Phone #:**_____

Physicians Signature: _____**Date:** _____

Physician NPI: _____ **State :**_____

Physician Address: _____**MTF:** _____

PATIENT SIGNATURE

By signing below I certify that: (i) I have read this form; (ii) I will receive a copy of this form with my equipment shipment; and (iii) I am the patient or a person duly authorized by the patient to lawfully execute this form and accept its terms on the patient's behalf.

Patient Name (Printed):_____DOB:_____

Patient/Representative Signature: _____ Date:_____

Relationship to Patient: _____

Patient's Phone # :(____) _____