



INNOVATIVE  
PROSTHETICS

# RX DISPENSING ORDER

---

THIS IS A REQUEST FOR **INNOVATIVE PROSTHETICS**  
TO EVALUATE AND TREAT THE FOLLOWING PATIENT

---

PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

SIDE AND LEVEL OF AMPUTATION: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

FACILITY PHONE NUMBER: \_\_\_\_\_

FACILITY CONTACT PERSON: \_\_\_\_\_

PHYSICIAN'S PHONE NUMBER: \_\_\_\_\_

PHYSICIAN'S NPI: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

---

**A STEP IN THE RIGHT DIRECTION**

**ADDRESS:** 935 S. Kimball Ave, Suite 170, Southlake, TX 76092   **PHONE:** 817.251.2220  
**FAX:** 866.981.5223   **WEB:** [www.innprosthetics.com](http://www.innprosthetics.com)