

**Prescription and Letter of Medical Necessity
For Vector I Hand Rehabilitation System**

**Physician: Please complete all sections and fax with supporting medical records to
Lantz Medical (877) 406-4872
Phone (866) 236-8889**

Patient Name: _____ Date of birth: _____

Primary Diagnosis (ICD-10 Code & Description): _____

Has surgery been involved? **YES or No:** If so when? _____

Date of Injury: _____

Reason device prescribed: Clinical advantage of the VECTOR I

- Strongest motor on the market to prevent rebound of unit during aggressive ROM
- Spring leaf caterpillars: malleable to increase ROM of specific phalanx
- Glove option to ease donning and doffing of unit-facilitates increased compliance
- Programmable force, ROM, and speed to accommodate vast clinical considerations for optimal outcomes
- ReRom feature to increase time spent in limited ROM addressing soft tissue limitations
- Expand feature for patient warm up
- Pause feature for increase low -load prolonged stretch to enhance tissue remodeling

Patient benefits:

The benefits of applying the VECTOR I are as follows but are not limited to:

- Increased Range of Motion (ROM) and tissue extensibility
- Decreased length of time for wound and soft tissue healing.
- Decreased rehabilitation and recovery time.
- Reduction in length of time to reach desired range of motion.
- Pain reduction through desensitization,
- These benefits are well documented in professional journals.

VECTOR I to be provided by: Lantz Medical

Length of prescription: _____ **Effective:** _____

ROM Parameters & Precautions: _____

MEDICAL NECESSITY CERTIFICATION

I, the undersigned, certify that the above prescribed equipment is medically necessary for this patient's well being. The equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition and is not prescribed as "convenience" equip.

VECTOR 1 CPM ONLY - NO SUBSTITUTIONS

Physician Signature: _____ Date: _____

Physician Name: _____ NPI _____

Address: _____

Phone Number # _____ Fax # _____