



T-JOE PECTUS BRACING SYSTEMS RX PRESCRIPTION



Date: ____ / ____ / ____

Patient's Name: _____

Date of Birth: ____ / ____ / ____

Diagnosis:

___ Pectus Carinatum
Q67.7

___ Flared Ribs / Pectus Excavatum
Q67.6

___ Dispense T-Joe Brace as indicated

___ Massage Therapy as indicated

___ Exercise / Workout Program as indicated

Ordering Physician:

_____ MD / DO
(print name or stamp)

Signature: _____

Address: _____

DEA / NPI : _____

Phone Number: (____) _____ - _____

Fax: (____) _____ - _____

Notes / Special Request: _____

877-732-8876
PectusServices.com