BALAJ MEDTECH INNOVATIONS LLC

General Referral Form

PHONE: 973-737-8454 | FAX: 832-598-0313

PATIENT DEMOGRAPHICS

Patient Name:	Patient Phone Number:
Date of Birth:	Address:
Allergies:	City / State / Zip:
Weight: _____ lbs or _____ Kg	Patient Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographic
- Most Recent Labs
- Medication List

PRIMARY DIAGNOSIS

- ICD-10 Code: _____

HEALTH ASSESSMENT (PLEASE CHECK ALL THAT APPLY) PAIN / ORTHOPEDIC CONDITIONS (BRACES)

☐ Chronic Back Pain ☐ Knee Pain / Osteoarthritis ☐ Shoulder Pain
☐ Elbow / Wrist Pain ☐ Limited Mobility / Instability ☐ History of Falls / Fall Risk
☐ Currently using pain medication

DIABETIC CONDITION (CGM – FREESTYLE LIBRE / SIMILAR)

☐ Diagnosed with Diabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes
☐ Difficulty with Fingerstick Testing ☐ Frequent Blood Sugar Monitoring Required ☐ On Insulin Therapy
☐ History of Uncontrolled Glucose Levels

BRACES (CHECK IF APPLICABLE):

☐ L0651 Lumbar Back Brace ☐ Knee Brace (L1833 / L1852) ☐ Wrist Brace (L3916)
☐ Elbow Brace (L3761) ☐ Ankle Brace (L1971) ☐ Shoulder Brace (L3660/L3670)
☐ Other: _____

Instructions:
Use as directed for support and pain relief.
Frequency: Daily / As needed
Duration: _____ months

CGM DEVICE (CHECK IF APPLICABLE):

☐ Freestyle Libre 3 Continuous Glucose Monitor(E2103)

Instructions:
Use as directed to continuously monitor glucose levels.
Frequency: Continuous
Duration: _____ months

☐ Freestyle Libre 3 Continuous Glucose Sensor(A4239)

Instructions:
Apply sensor to the back of the upper arm as directed. Replace sensor per manufacturer guidelines.
Frequency: Continuous use – Sensor refill required every month
Duration: ☐ 3 Months ☐ 6 Months ☐ 12 Months (or as medically necessary)

MEDICAL NECESSITY STATEMENT

Patient has a medical condition that requires the above DME as documented in chart notes.
This equipment is medically necessary to improve patient health and daily function.

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City / State / Zip:	Fax:
NPI AND License:	Email:

_____ _____
Provider Signature Date