

Game Ready Pneumatic Compression + Cryotherapy Unit

Patient Rental Information Sheet

To reserve a GameReady device – please call 613 686 4557

Your surgeon has prescribed the Game Ready System for you to assist with your recovery from surgery or injury. Game Ready is the injury treatment of choice of thousands of prominent orthopaedic clinics and physical therapy centres as well as teams and athletes in almost every professional and competitive sport.

This document will provide you with information regarding the rental of a Game Ready Unit and common questions that might arise in its usage by patients at home.

WHAT: THE Game Ready System combines intermittent pneumatic compression and cooling in a single system to provide treatment to an injury or during post-surgical recovery.

WHY: Intermittent compression with cryotherapy has been shown to decrease the amount of localized edema and pain to a joint or area, allowing greater range of motion and earlier recovery and return to full function.

PROTOCOL: This system will only be applied while at rest and is not intended for use while active.

- 1) **Initial usage** – Acute injury or immediate post-op with or without post-op dressings or bandage (usually up to 72 hours or as tolerated by individual):
 - Apply the system 30 minutes ON and 60 minutes OFF at a low compression of 5-15 mmHg (Program 5) while you are awake.
 - If uncomfortable change to Program 4 which will apply no pressure, only cooling.
 - If you experience any increase in pain or discomfort even at Program 4, we recommend stopping usage immediately and consult your referring physician, rehab specialist or Kinemedics representative.
- 2) **Continued Usage** – After post-op dressings are removed or as tolerated after initial 72 hours
 - A 4x4 gauze bandage with a tubi-grip compression sleeve over the dressing should be applied before applying the Game Ready Sleeve.
 - Apply the Game Ready system for 30 minute ON and 60 minutes OFF (Program 5) with low compression (5-15 mmHg) while you are awake.
 - The amount of compression may be increased to medium (5-25 mmHg) if tolerated.
 - Once again, please let us know if you experience any increase in pain or discomfort; the system can be stopped immediately any time.

Rx Physicians Prescription

Date ____/____/____

Patient's Name: _____

Surgical _____ Non-Surgical _____

I am prescribing a motorized vasopneumatic compression and motorized cold therapy system due to my patient's needs and diagnosis. I certify that the device is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

Product: Kodiak Wave™, Game Ready™, or Kodiak™ *Original* motorized cold therapy control unit, complete with motorized pneumatic compression & cold wrap / cuff / garment.

Wrap required: knee ☒ hip shoulder ankle back

Side treated: Left Right

Rx Physicians letter of medical necessity

I am writing on behalf of my patient that you approve coverage for a self contained, motorized, vasopneumatic compression and cold therapy system with associated cuff / wrap. I consider this device medically necessary and I am prescribing this device for the purpose of musculoskeletal injury treatment and/or post-operative treatment.

The system combines compression and cold therapies. It is intended to treat post-surgical and acute injuries to reduce edema, swelling and pain where cold and compression are indicated.

RICE (Rest, Ice, Compression, Elevation) has long been used to treat acute and chronic injury and assist in rehabilitation following orthopaedic surgery. This device combines the two most difficult to manage aspects of the RICE regime (Ice and Compression) by offering cold and intermittent compression to all major joints.

The anatomically designed wraps are engineered for all major body parts and utilize intermittent pneumatic compression and fluid circulation technology, simultaneously delivering circumferential cold and compression.

My post-operative care and rehabilitative care plan calls for the use of the device to reduce pain and swelling. I certify that the above described product is medically indicated and in my opinion is reasonable and necessary. Given the safety and effectiveness of this unit, I prescribe and recommend that the patient use this device daily.

If you have any questions, please feel free to contact me directly.

Physician signature: _____

Date: _____

Physician printed name: Dr. Simon Garceau

Office phone : 613-737-8081



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