



## DWO for Electrotherapy Services

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND  
SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER: \_\_\_\_\_

DATE OF LAST FACE TO FACE: \_\_\_\_\_

### PATIENT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

### REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name \_\_\_\_\_ Therapist Name \_\_\_\_\_

Clinic Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Therapist Email \_\_\_\_\_

### PRODUCT PRESCRIBED

IF Unit and Monthly Supplies/Accessories

NMES Unit and Monthly Supplies/Accessories

4-Lead Tens Unit and Monthly Supplies/Accessories

Conductive Garment - Please choose      Glove      Sleeve      Knee      Sock      Back

### LENGTH OF NEED AND MEDICAL NECESSITY

Purchase (99=Lifetime)

### DIAGNOSIS

Primary ICD10 Numeric Code: \_\_\_\_\_

Secondary ICD10 Numeric Code: \_\_\_\_\_

If prescribing NMES Unit and Supplies, the following diagnosis must be selected:

**M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site**

### PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

*By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.*

Physician Name \_\_\_\_\_ NPI# \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physician Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date Signed \_\_\_\_\_