

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 _____