

SECTION 1 — PATIENT & INSURANCE INFORMATION REQUIRED

Patient Name _____ DOB (MM/DD/YY) ____________ Gender _____
 Address _____ City _____ State _____ ZIP _____
 Primary Phone _____ Secondary Phone _____ Email _____
 Primary Insurance _____ Member ID _____ Primary Language, if not English _____
 Secondary Insurance _____ Member ID _____ Is this a workplace injury? Yes No

If patient is not insured, write SELF PAY in this section

Please attach medical records and copies of the front and back of all insurance cards with each order.

SECTION 2 — PRESCRIBED THERAPY REQUIRED

Length of Need: _____ (1-24 months) **Days Per Week:** _____ (1-7) **Sessions Per Day:** _____ (1-5) **Minutes Per Session:** _____ (15-60 mins)

SELECT MODALITIES

TENS, 2-Lead **TENS, 4-Lead**

- Acute Postprocedural Pain (G89.18)
- Chronic Postprocedural Pain (G89.28)
- Chronic Pain Syndrome (G89.4)
- Other: _____

If Chronic:

TENS Trial Conducted
 Date Range: ____________ - ____________
 No Trial Conducted

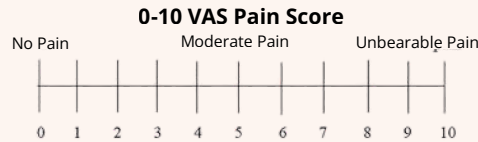
If Acute:

Date of injury or Surgery: ____________

Will or **will not** likely derive significant benefit from continuous use of the therapy over a long period of time.

IFC

Pain Score (VAS): _____
 Pain Duration (months): _____
 Diagnosis: _____
 Functional Limitation: _____



NMES

Body Area	Left	Right
Shoulder	<input type="checkbox"/> M62.512	<input type="checkbox"/> M62.511
Upper Arm	<input type="checkbox"/> M62.522	<input type="checkbox"/> M62.521
Forearm	<input type="checkbox"/> M62.532	<input type="checkbox"/> M62.531
Hand	<input type="checkbox"/> M62.542	<input type="checkbox"/> M62.541
Thigh	<input type="checkbox"/> M62.552	<input type="checkbox"/> M62.551
Lower Leg	<input type="checkbox"/> M62.562	<input type="checkbox"/> M62.561
Ankle/Foot	<input type="checkbox"/> M62.572	<input type="checkbox"/> M62.571

Cause of Atrophy:

- Casting or Splinting of a Limb
- Contracture Due to Scarring of Soft Tissue
- ACL Repair/Knee Replacement Leading to Quad Atrophy
- Other: _____

Nerve Supply intact?

- Yes
- No

Other Single Site (M62.58): _____ (Specify)
 Other Diagnosis: _____ (Specify)

SECTION 3 — SUPPLIES REQUIRED

Initial Order includes:

- Lead Wires (1 set)
- AC Adapter (1 unit)
- Batteries (4 each)
- Electrodes (16 - 2" round (4x4/pk))

Garment(s):

- Conductive**
- Elbow
 - Knee
 - Sock
 - Glove, Small (7" x 3")
 - Glove, Large (8.5" x 3.5")

Non-Conductive

- Care Vest: Chest circumference: _____ in
- Back: Waist circumference: _____ in
- Lumbar: Lumbar circumference: _____ in
- Shoulder: Chest circumference: _____ in
- Neck: Neck circumference: _____ in

Reason the Garment(s) Are Necessary:

SECTION 4 — PRESCRIBER ATTESTATION REQUIRED

By signing below, I confirm that the patient is being treated by me. All the information contained on this form accurately reflects the patient's medical condition and the treatment regimen I have prescribed. The medical records for this patient substantiate the prescribed treatment frequency. The patient/caregiver is able to follow instructions for using an e-stim device and is able to use the ordered items. I certify my patient has no medical contraindications making this therapy inappropriate, e.g., pace-maker. For Medicare/insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Name: _____ **License:** _____ **NPI:** _____
Clinic Name: _____ **Phone Number:** _____ **Fax Number:** _____
Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Prescriber Signature: _____ **Date:** _____