



Please provide the information requested below and complete the form in full.

Clinic Information

Clinic Name \_\_\_\_\_ Acct# \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_
Clinic Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Contact \_\_\_\_\_
Sales Representative \_\_\_\_\_ Territory # \_\_\_\_\_ Phone \_\_\_\_\_

Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Date of Injury/Onset \_\_\_\_\_

Prescription

Product: [ ] Phoenix NMES device and Conductive Garment [ ] Phoenix NMES device only [ ] Phoenix Conductive Garment only

Diagnosis: ICD-9 \_\_\_\_\_ ICD-9 \_\_\_\_\_ ICD-9 \_\_\_\_\_

Prognosis: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Prior Treatments: [ ] Prior Surgery [ ] NSAIDS/meds [ ] PT [ ] Injections [ ] Other \_\_\_\_\_

Primary Use: [ ] Treatment of Disuse Atrophy [ ] Re-Educate Muscles [ ] Other \_\_\_\_\_

Length of Need: [ ] Purchase (Lifetime=99) [ ] \_\_\_\_\_ #Months

Supplemental Questions:

Is the NMES prescribed for treatment/retarding disuse atrophy? [ ] Yes [ ] No

State the condition(s) causing the disuse atrophy: \_\_\_\_\_

How long has the atrophy been present: \_\_\_\_\_

Is the nerve supply to the involved muscle intact? [ ] Yes [ ] No

Specify the nerves/muscles being strengthened: \_\_\_\_\_

Will the use of NMES result in increased muscle function/strengthening? [ ] Yes [ ] No

Is the unit being prescribed pursuant to a written plan for rehabilitation due to injury or a major surgery? [ ] Yes [ ] No

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Physician Signature \_\_\_\_\_ Date of Signature: \_\_\_\_\_

By my signature, I am prescribing the item listed above. In my judgment, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition. Please make sure the above information is substantiated in your patient's medical record.

\*Signature stamps are not permitted for Medicare. DO NOT SUBSTITUTE

