Prescription Form

Patient Name:_____ Date of Birth: _____

Street Address: _____

City:_____State:___ Zip Code:_____ Phone Number: (___)____-_____

Rx: Neuromuscular Electrical Stimulation for Disuse Atrophy and Muscle Re-education

_____ _____

PHYSICIAN SIGNATURE DATE

Name of Physician:_____ NPI: _____

Street Address: _____

City:_____State:___ Zip Code:_____ Phone Number: (___)____-_____