

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: (____) ____ - _____