Prescription Form

(Electrical Stimulation)

Patient Name:_______________________________________ Date of Birth: ________________

Street Address: ____

City:________________________ State:___ Zip Code:_______ Phone Number: (___) ____-_____

Diagnosis:____

Product Prescribed:

- ☐ Saebo MyoTrac Infiniti
- ☐ *Saebo***Stim Go**
- ☐ Other ______________________________________

I, the undersigned, certify that the above equipment is medically necessary for this patient's well-being and recovery from the aforementioned diagnosis. In my opinion the equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition and is not prescribed as convenience equipment. I am knowledgeable of the contraindications for use of electrical stimulation and certify that this patient is safe to obtain and use this product.

_____________________________________ ____________________

PHYSICIAN SIGNATURE DATE

Printed Name of Physician:__________________________________ NPI: __________________

Street Address:____

City:________________________ State:___ Zip Code:_______ Phone Number: (___) ____-_____