

PREScription ORDER FORM

____ This is an Urgent Care Request (requests made within 24 hours of procedure)

PATIENT NAME (Print): _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

HOSPITAL _____ SX DATE/TIME: _____

DX/ICD-9 CODE(s): _____

DURATION OF USE (for rental, circle one): 1 week – 2 weeks – 3 weeks

Equipment (Check):

____ TEC System (Iceless **Cold** Compression Device) **with DVT** Calf or Foot None

Standard Frequency: 20 Minutes On / 20 Minutes Off - 3x per Day or As Tolerated

Alternate Frequency: _____

____ TEC System (Iceless **Heat** Compression Device) **with DVT** Calf or Foot None

Standard Frequency: 1 Hour 4x per Day or As Tolerated

Alternate Frequency: _____

____ TEC System (Iceless **Contrast** Compression Device) **with DVT** Calf or Foot None

Standard Frequency: 1 Hour 4x per Day or As Tolerated

Alternate Frequency: _____

____ CPM for Knee ____ CPM for Shoulder (Circle One – LEFT or RIGHT)

Standard Frequency: 2 Hours, 3X per Day, Non-Continuous

Alternate Frequency: _____

____ Muscle Stim Unit ____ TENS Unit

Physician

Signature: _____ **Date:** _____

Physician Name

NPI #

Office Address

City

State

Zip Code

Telephone #

Fax #

FAX ORDERS TO (602) 265-1551

*****PLEASE ATTACH PATIENT INFORMATION AND COPIES OF INSURANCE CARDS*****