



# Prescription Form

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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: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_