T.E.N.S. UNLIMITED INC

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Tricare Doctors Written Order

Patient Demographic (MUST complete)

Name: _____ DOB: _____/_____/_____Order Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____Email: _____

Please check that all apply

____ TENS Unit (E0730) _____ EMS Unit (E0745) _____ Bone Stim (E0747-49) _____Conductive Garment (E0731)

____ Lead wires (A4557) _____ Conductive spray (A4556) _____ Electrodes (A4595) _____ 9vt Battery (A4630)

Please complete the following:

Location of pain: Primary diagnosis: _____, Secondary diagnosis: _____

Duration of the time with pain: _____

Prior treatment: _____, _____, _____.

Length of need: _____, *Frequency:* _____, *Prognosis:* _____.

Utilizing accepted medical practice standards; the above prescribed DME is essential in the continues of treatment of the patient to treat their condition and return them back to their Activities of Daily Living (ADL's).

Physician Name: _____ NPI: _____

Provider Signature: _____ Date Signed: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____

Fax number: _____

TENS Unlimited Inc. use ONLY

RCD Date: ___/___/_____ Intl: _____