NeuroZen

— INNOVATE. RESTORE. EMPOWER. —

actiTENS®

Professional Electrotherapy for Recovery and Relief.

PRESCRIBED BY DOCTORS
actiTENS is prescribed by licensed healthcare providers to support your recovery.

PHYSICIAN PRESCRIPTION & ORDER FORM

1. PATIENT INFORMATION

Patient Name: _____ DOB: _____ DOI: _____ Phone: _____

Attorney: _____ Claim #: _____ Provider: _____ NPI #: _____

2. DIAGNOSIS (CHECK ALL THAT APPLY)

- ☐ Concussion
- ☐ Mild TBI
- ☐ Post-Concussion Syndrome
- ☐ Headache
- ☐ Migraine
- ☐ Occipital Neuralgia
- ☐ Dizziness / Vertigo
- ☐ Acute Pain
- ☐ Chronic Pain
- ☐ Neuropathic Pain
- ☐ Myofascial Pain
- ☐ Muscle Spasm
- ☐ Whiplash
- ☐ Cervicalgia
- ☐ Radiculopathy
- ☐ Other: _____

3. PAIN LOCATION (CHECK ALL THAT APPLY)

- ☐ Head
- ☐ TMJ / Jaw
- ☐ Neck
- ☐ Left Shoulder
- ☐ Right Shoulder
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Left Arm
- ☐ Right Arm
- ☐ Left Hand / Wrist
- ☐ Right Hand / Wrist
- ☐ Left Hip
- ☐ Right Hip
- ☐ Left Knee
- ☐ Right Knee
- ☐ Left Ankle / Foot
- ☐ Right Ankle / Foot
- ☐ Other: _____

4. PAIN SCORE (CIRCLE ONE)

0 (No Pain) — 1 2 3 (Mild) — 4 5 6 (Moderate) — 7 8 (Severe) — 9 10 (Worst Possible)

5. NEUROZEN PROTOCOL (CHECK ONE)

- ☐ TBI Protocol
- ☐ Concussion Protocol
- ☐ Whiplash Protocol
- ☐ Cervical Pain Protocol
- ☐ Custom Protocol (specify below)

Details: _____

6. PRESCRIBED DEVICE

- ☑ **NeuroZen actiTENS® Professional Electrotherapy Device**
  Portable, prescription electrotherapy device for pain relief and recovery.

Other NeuroZen Devices (if applicable):

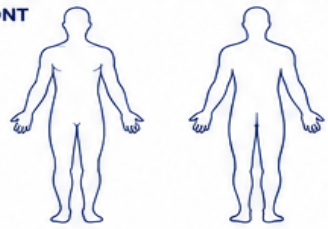
- ☐ Cold Compression Therapy
- ☐ Hot/Cold Therapy
- ☐ Cervical Support Device
- ☐ Other: _____

7. TREATMENT GOALS (CHECK ALL THAT APPLY)

- ☐ Pain Reduction
- ☐ Decrease Muscle Spasm
- ☐ Reduce Inflammation
- ☐ Increase Range of Motion
- ☐ Improve Function
- ☐ Improve Nerve Function
- ☐ Improve Activities of Daily Living
- ☐ Support Concussion Recovery

8. BODY MAP – MARK AREAS OF PAIN

FRONT BACK



9. PROVIDER CERTIFICATION

I certify that the above patient has been evaluated by me and that the use of the NeuroZen actiTENS® Professional Electrotherapy Device is medically necessary to treat the condition(s) listed above.

Provider Signature: _____ Date: _____

Printed Name: _____

NPI #: _____ DEA #: _____

This order is valid for 6 months from the date above.

1-800-768-2825