Patient & Clinic Information

PATIENT DOB ___ ___ / ___ ___ / ___ ___ Sex_____(M/F)

PATIENT NAME_____

☐ WORKERS COMPENSATION ☐ PERSONAL INJURY

Attach Complete Demographic sheet with Complete Work Comp or Attorney Info

Attorney / Adjuster NAME:_____

Attorney / Adjuster PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

MOBILE PHONE(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

PHONE(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

DATE OF INJURY: ___ ___ / ___ ___ / ___ ___

INSURANCE_____

EMPLOYER_____

CLAIM #_____

INSURANCE PHONE (_____) ___ ___ ___ -___ ___ ___ ___

PHYSICIAN NAME _____

FACILITY NAME _____

FACILITY ADDRESS _____

CITY _____

STATE ___ ___ ZIP ___ ___ ___ ___ ___

PHONE (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

FAX (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

NPI # _____

OFFICE CONTACT _____

Please fax completed form and Clinical Notes to:
A&O Medical, Authorized Distributor

fax: (727) 245-8442

or email to:
orders@aomedical.net
phone: (941) 739-0155

Physician Prescription

Please Complete All Appropriate Boxes

ICD 10:_____, _____, _____ **Surgery Date:**_____ **Side** ☐ Left ☐ Right **Body Part**

☐ Knee ☐ Shoulder ☐ Elbow ☐ Lumbar ☐ Cervical ☐ Hand/Wrist ☐ Foot/Ankle ☐ Other_____

☐ **Tru Stim PRO Bundle NMES E0745, With Anatomic Garment E0731**

"DO NOT SUBSTITUTE" **Supplies – A4595:** ***Requires a quantity of 2 packs of supplies per month***

☐ 2 Month ☐ 4 Month

PHYSICIAN'S SIGNATURE:_____DATE___ ___ / ___ ___ / ___ ___

PHYSICIAN'S PRINTED NAME: _____

Consultant - Cory Steiner
(800) 366-8051
(215) 791-0674 cell
(215) 689-1558 fax
eortho@aol.com
https://eortho.com

Billing Contact - A&O Medical (941) 739-0155 office
(727) 245-8442 fax

***Please include Clinical Notes to expedite this request.**