T.E.N.S

Unlimited INC.

Phone: (808) 722-0226
Email: hawaii@tensunlimited.com
Web: Tensunlimited.com

Durable Medical Equipment

FAX TO: (808) 200-0391

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: ___/___/_____ ORDER DATE: ___/___/_____

PHONE: ____-____-_____ ADDRESS: _____ CITY: _____ STATE/ZIP: _____

*********PLEASE PROVIDE DEMOGRAPHIC AND OFFICE NOTES FOR PROCESSING**********

ORDER INFORMATION

BRACING
_____ OA KNEE BRACE
_____ POST- OP ROM BRACE
_____ PNEUMATIC WALKING BOOT
_____ BACK BRACE
_____ CONDUCTIVE GARMENT

THERAPIES:
_____ TENS UNIT
_____ EMS UNIT
_____ BONE GROWTH STIMULATOR
_____ PNEUMATIC COMPRESSION DEVICES

MOBILITY SUPPORTS:
_____ CRUTCHES (SIZES: Y M L)
_____ WALKER W/ 2 WHEELS & BAG
_____ HEAVY DUTY KNEE WALKER
_____ HEAVY DUTY KNEE SCOOTER

TENS/EMS UNIT SUPPLIES:

_____ LEAD WIRE _____ ELECTRODES _____ BATTERY _____ CONDUCTIVE SPRAY _____ ADHESIVE REMOVER

I certify that I am the physician identified in this form. I have reviewed the detailed written order. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I will provide medical documentation to help with the DME processing. I acknowledge that the patient is aware that DME may contact them for any additional information to process this order. A copy of this order will be retained as a part of the patient's medical record.

REQUESTING PHYSICIAN INFORMATION

Physicians Name: _____ NPI: _____
Signature: _____ Signed Date: _____/_____/_____
Contact Phone: _____-_____-_____ Contact Fax: _____-_____-_____
Address: _____ City: _____ State/Zip: _____