T.E.N.S

Unlimited INC.

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Durable Medical Equipment

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650 Iwilei Rd. Suite#290
Honolulu, HI 96817

PATIENT INFORMATION:

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

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

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

ORDER INFORMATION

BRACING	THERAPIES:	MOBILITY SUPPORTS:
____ OA KNEE BRACE	____ TENS UNIT	____ CRUTCHES (SIZES: Y M L)
____ POST- OP ROM BRACE	____ EMS UNIT	____ WALKER HEAVY DUTY ONLY
____ PNEUMATIC WALKING BOOT	____ BONE GROWTH STIMULATOR	____ HEAVY DUTY KNEE WALKER
____ BACK BRACE	____ PNEUMATIC COMPRESSION DEVICES	____ HEAVY DUTY KNEE SCOOTER
____ CONDUCTIVE GARMENT	____ PERIPHERAL NERVE STIM	____ QUAD CANE (WE PROVIDE W/ BRACE ORDER)

____ Other: Please Specify: _____

Diagnosis Code(s) ICD-10: _____, _____, _____

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: _____