

T.E.N.S

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Durable Medical Equipment

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Honolulu, HI 96817

PATIENT INFORMATION:

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

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

INSURANCE NAME & ID: _____ - _____ EMAIL: _____

ORDER INFORMATION

BRACING

- ___ OA KNEE BRACE
- ___ POST- OP ROM BRACE
- ___ PNEUMATIC WALKING BOOT
- ___ BACK BRACE
- ___ CONDUCTIVE GARMENT
- ___ OTHER PLEASE SPECIFY: _____

THERAPIES:

- ___ TENS UNIT
- ___ EMS UNIT
- ___ BONE GROWTH STIMULATOR
- ___ PNEUMATIC COMPRESSION DEVICES
- ___ PERIPHERAL NERVE STIM

MOBILITY SUPPORTS:

- ___ CRUTCHES (SIZES: Y M L)
- ___ WALKER W/ 2 WHEELS & BAG
- ___ HEAVY DUTY KNEE WALKER
- ___ HEAVY DUTY KNEE SCOOTER

Diagnosis Code(s): _____, _____, _____

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: _____