REHABTRONICS
TECHNOLOGY FOR RECOVERY

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Prescription Form

Patient Name: _____ Date of Birth (yy/mm/dd): ___ / ___ / ___

Street Address: _____

City: _____ State: ____ Zip Code: _____ Phone Number: (___) _____ - _____

Rx: Neuromuscular Electrical Stimulation for Disuse Atrophy and Muscle Re-education

_____ _____
Physician Signature Date

Name of Physician: _____ NPI: _____

Street Address: _____

City: _____ State: ____ Zip Code: _____ Phone Number: (___) _____ - _____