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: (_____) _____-_____

Fax: (780) 701-5167