HANDI MEDICAL SUPPLY

Detailed Written Order: Neuromuscular Electrical Stimulator

Handi Customer Number

Step 1 Patient Information

Date of Last Eval: _____ **Start Date:** _____

Name: _____ **DOB:** _____

Diagnosis(ICD10): _____

Step 2 Product Information

☐ **NMES (E0745)** ☐ **Functional Electrical Stimulator (E0770)** Frequency of use: _____

Other supplies	Frequency of use

Step 3 Estimated Length of Need: _____

Step 4 Please complete the following questions

Is there disuse muscle atrophy?

What is the cause of the disuse atrophy?

Is the nerve supply to the affected muscles intact?

Does the patient need a functional electrical stimulator? ☐ Yes ☐ No

Does the patient have upper limb paralysis due to cervical spinal cord injury or stroke?

Additional comments:

PLEASE INCLUDE MEDICAL RECORDS

Step 5 Physician Signature Date

Physician Information (must match signature above)

Dr. Name(Print): Lic#: NPI#:

Address: Suite: Phone#:

City: State: Zip: Fax#:

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