Current Technology, Inc. 2001 Regent Avenue North Minneapolis, MN 55422 Tel: 800-322-4461
Fax: 763-588-0066

PRESCRIPTION FOR PELVIC FLOOR ELECTRICAL STIMULATOR (E0740) ☐

Patient's Name _____

Patient's Address _____
(Street Address) (City) (State) (Zip)

Patient's Phone_____D.O.B._____

Patient Needs (please check one) Vaginal Probe____ Rectal Probe____

The patient has undergone and failed in a documented trial of
pelvic muscle exercise training prescribed for a duration of 4 weeks . YES___ NO___
Are the results documented in the patient's medical notes? YES___ NO___
Is the patient cognitively intact? YES___ NO___

Diagnosis (please circle):
N39.41 urge incontinence N39.3 stress incontinence (female)(male)

N39.46 mixed incontinence (female) (male)

CERTIFICATE OF MEDICAL NECESSITY

The above identified equipment is deemed medically necessary for an estimated period of time below:

☐ Purchase for long term use
No substitutions

Physician's Name _____
(Please print)

Address _____
(Street Address) (City) (State) (Zip)

Phone_____Fax_____

NPI_____

Physician's Signature Date