PRESCRIPTION FOR PELVIC FLOOR ELECTRICAL STIMULATOR (E0740)

Patient's Name _____

Patient's Address _____
Street City State Zip

Patient's Phone_____D.O.B._____

The patient has undergone and failed a documented trial of pelvic muscle exercise training prescribed for a duration of 4 weeks which include _____Yes ☐ No ☐

Previous Treatments / Medications tried: _____

Are the results documented in the patient's medical notes? Yes ☐ No ☐
(Attach Physical Therapy Notes from week 1 (Co-signature required) and week 4)

Is the patient cognitively intact? Yes ☐ No ☐

Would the patient benefit from home-use with the pelvic floor e.stim? Yes ☐ No ☐

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

N39.46 mixed incontinence (female) (male) R15.9 full incontinence of feces

Other: _____

CERTIFICATE OF MEDICAL NECESSITY

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

- ✓ Purchase
- ✓ No substitutions

Physician's Name _____
(Print)

Address _____
Street City State Zip

Phone_____ Fax_____

NPI_____

Physician's Signature Date

Current Technology, Inc. 800-322-4461 (t) 763-588-0066 (f)