DWO for Electrotherapy Services

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER:_____
DATE OF LAST FACE TO FACE:_____

PATIENT INFORMATION

First Name_____ **Last Name**_____

Address_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

Date of Birth_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name_____ **Therapist Name** _____

Clinic Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Fax**_____

PRODUCT PRESCRIBED

☐ IF Unit and Monthly Supplies/Accessories

☐ NMES Unit and Monthly Supplies/Accessories

☐ 4-Lead Tens Unit and Monthly Supplies/Accessories

☐ Conductive Garment - **Please Circle:** Glove / Sleeve / Knee / Sock / Back

LENGTH OF NEED AND MEDICAL NECESSITY

☐ Purchase (99=Lifetime)

DIAGNOSIS

☐ **Primary ICD10 Numeric Code:**_____

☐ **Secondary ICD10 Numeric Code:**_____

If prescribing NMES Unit and Supplies, the following diagnosis must be selected:

☐ **M62.50 Muscle wasting and atrophy, not elsewhere classified, unspecified site**

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Physician Name_____ **NPI#**_____ **Phone**_____ **Fax**_____

Physician Address_____ **City**_____ **State**_____ **Zip**_____

Physician Signature_____ **Date Signed**_____