



PRESCRIPTION & LETTER OF MEDICAL NECESSITY

PATIENT NAME*

DOB*


DATE OF INJURY

DATE OF SURGERY

PRIMARY PHONE*

SECONDARY PHONE/ EMAIL

E-STIM

-  Zynex NexWave + Monthly Supplies and a Conductive Garment when applicable

Length of Need: Life-time 3-18 Months
(if unchecked = Life-time)

DX Code(s) _____

Treatment Area: Neck Shoulder Back

Hand Foot Elbow/Knee

-  Zynex E-Wave (NMES Only) + Monthly Supplies

Other: _____

Substitution for this device is NOT ALLOWED without my written approval



BRACING



(FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT)

- Aspen Horizon Lumbosacral Orthosis (Prefabricated) (Purchase Only)

DX Code(s) _____

- Zynex Pro OA Knee (Prefabricated) (Purchase Only)

Quantity to be Dispensed: _____

Frequency of Use: _____

Knee: Right Left

Please document in patient's chart the reason(s) for prescribing and fax with Rx



CERVICAL TRACTION



(FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT)

- Cervical Traction (Purchase Only) (Saunders or ComforTrac)

DX Code(s) _____



HOT/COLD THERAPY

(FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT)

- JetStream® Hot/Cold circulating pump & therapy blanket

Length of Need: 15 Days 30 Days 45 Days Other ___ Days

DX Code(s) _____

I have reviewed the hot/cold therapy contraindications on the back of this prescription prior to prescribing for patient.

CLINIC ADDRESS

CITY

ST.

ZIP

PHONE

FAX

PRESCRIBER'S SIGNATURE*

DATE*

PRINTED NAME*

NPI*



IF THIS DEVICE WAS REQUESTED BY ANOTHER MEDICAL PROVIDER, PLEASE INCLUDE THEIR NAME/ADDRESS/ZIP HERE

I CERTIFY THAT THE EQUIPMENT AND SUPPLIES I PRESCRIBED ARE MEDICALLY NECESSARY FOR THIS PATIENT'S WELL-BEING; THIS IS NOT PRESCRIBED AS CONVENIENCE EQUIPMENT. IN MY PROFESSIONAL OPINION, THE EQUIPMENT IS BOTH REASONABLE AND NECESSARY IN REFERENCE TO THE ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT FOR THIS PATIENT'S CONDITION. **SUBSTITUTION FOR THIS DEVICE IS NOT ALLOWED WITHOUT MY WRITTEN APPROVAL.**

FAX RX To: +1 (800) 495-6695

Email RX To: orders@zynex.com

Additional Device Information

Cervical Traction

Our Home Cervical Traction Devices are medically necessary because the patient requires greater than 20 pounds of force.

Please Review Hot/Cold therapy contraindications prior to prescribing for patient

CONTRAINDICATION - WHEN NOT TO USE HOT THERAPY

DO NOT use hot therapy on patients with any of the following contraindications:

- History of heat injury or adverse reactions to hot therapy
- Incoherence due to sedation, anesthesia, coma or sleep
- Decreased skin sensitivity or localized circulation or wound healing problems
- Arteriosclerosis or atherosclerosis
- Localized malignancy in treatment area
- Hypersensitivity to heat
- Local tissue infection, swelling or inflammation

DO NOT APPLY ABDOMINALLY IF PREGNANT

CONTRAINDICATION - WHEN NOT TO USE COLD THERAPY

DO NOT use cold therapy on patients with any of the following contraindications:

- History of cold injury, frostbite or adverse reactions to cold therapy
- Incoherence due to sedation, anesthesia, coma or sleep
- Decreased skin sensitivity or localized circulation or wound healing problems, including those caused by multiple surgical procedures
- Circulatory syndromes due to Raynaud's disease, Buerger's disease, peripheral vascular disease, vasospastic disorders, or hypercoagulable clotting disorders
- Hand/wrist or foot/ankle surgery exhibiting polyneuropathy
- Hypersensitivity to cold
- Local tissue infection
- Diabetes

DO NOT USE ON CHILDREN UNDER 12 YEARS OF AGE

Please Fax To: +1 (800) 495-6695

Include Patient Demographics

****Please include patient chart notes supporting Rx****

IMPORTANT GIVE TO PATIENT

HERE'S HOW TO OBTAIN YOUR PRESCRIBED MEDICAL DEVICE

Step 1

- Zynex will text and call you
(usually the same day we receive your Rx!)



Step 2

- Have your medical insurance



Step 3

- Zynex will ship your device



You can learn how to use the NexWave by watching the instructional video at
<http://www.zynex.com/nw>

If you have not heard from us within 24 hours, please call Patient Support at (800) 495-6670. You may also go online to complete your order at www.zynex.com/ship or by scanning here:



Equipment Use Protocol

Patient Name _____

Spinal Bracing Equipment Use Protocol

Pain Management Use

Wear ____ min./day and increase wear time by ____ min. every ____ day(s)

Wear spinal brace while performing the following:

Sitting Standing Walking Exercising Other _____

Instructions: _____

Post Operative Use

Day ____ through Day ____ Wear continuously with a break of ____ min. every ____ hour(s)

Day ____ through Day ____ Wear continuously with a break of ____ min. every ____ hour(s)

Wear spinal brace while performing the following:

Sitting Standing Walking Exercising Other _____

Instructions: _____

Cervical Traction Equipment Protocol (Tx = Treatment)

Choose Degree of Flexion: 10° 15° 20°

Tension Type: Sustained ____ lbs. of Force ____ min./Tx ____ Tx/Day

Tension Type: Intermittent ____ lbs. of Force ____ min. of ON Time ____ min. of OFF Time ____ Tx/day

Hot/Cold Therapy Equipment Use Protocol (Tx = Treatment)

Cold Therapy (40° - 50°):

Day ____ through Day ____ Use continuously with a break of ____ min. every ____ hour(s)

Day ____ through Day ____ Use: ____ min./Tx every ____ hour(s)

Use after exercise for ____ min./Tx

Hot Therapy: (80° - 120°)

Use after day number ____ Before exercise: ____ min./Tx

Loosen stiff muscles/Joint: ____ min./Tx

See Back For: "How to Obtain Your Prescribed Device"