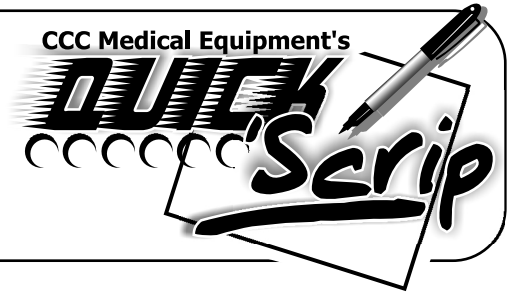


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Agency Information

Agency Name: _____

Diagnosing Physician's Name: _____

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ Cellular: (____) _____

Insurance Carrier: _____

Group # _____ Policy # _____

Patient SSN # _____ - _____ - _____ DOB: _____

DX

- TENS Unit
- Heat Pump
- Cervical Traction
- Other _____

Physician's Signature _____

Date of Order: _____