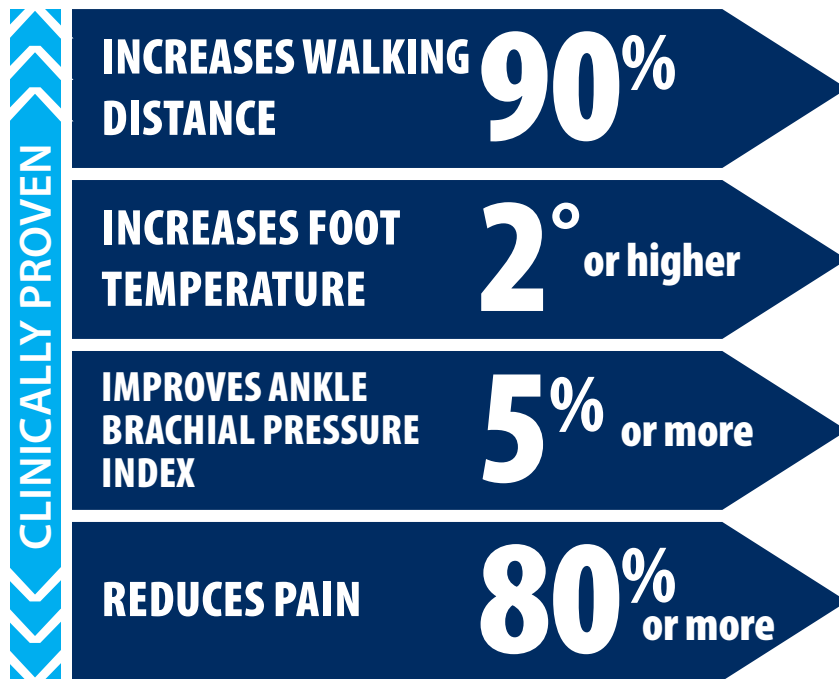




DIABETES + CLAUDICATION

Here is the new solution
VEINOPLUS[®]
Vascular



Two, one hour sessions per day

Pocket size. Safe. Easy to use. No risk of ischemia. Positive results.

Transcutaneous calf-muscle electro-stimulation: a prospective treatment for diabetic claudicants?

Ellul Ch. Gatt A., Diabetes & Vascular Disease Research 2016, Vol. 13(6) 442-444

Physician Information

Physician Name: _____ NPI: _____ Order Date: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____ Fax #: _____

Patient

First Name: _____ Last Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____ DOB: _____ Gender: M F

Dispensing Instructions

VeinOPlus Vascular (E0745) – 1 unit

Est length of need = 99 months

Perform one hour session _____ times per day

VeinOPlus Vascular Electrodes (A4595)

Number of Refills:

1 2 3 4 5 6 7 8 9 10 11 12

Medical Need/Diagnosis

Please check (v) the diagnosis leading to Calf Muscle Pump Dysfunction:

- Disuse Muscle Atrophy (M62.561) Location - Right Lower Limb
- Disuse Muscle Atrophy (M62.562) Location – Left Lower Limb

****Contraindications:** Wearers of cardiac pacemakers and/or defibrillators should not use the VeinOPlus®

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate, and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed, and physician notes and other supporting documentation will be provided to VasoCARE, LLC upon request. I understand any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician Signature

(Stamps are not acceptable)

Physician's Printed Name

Date

Please fax signed and dated PWO, Medical Records, and Face Sheet to 866-455-5150