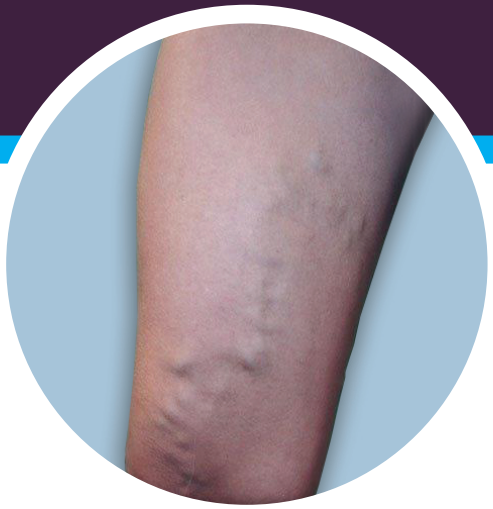
ENDOVENOUS LASER TREATMENT/ RADIOFREQUENCY ABLATION FOR VARICOSE VEINS + REPERFUSION EDEMA + DVT



Here is the new solution

VEINOPLUS®

Vascular

CLINICALLY PROVEN

INCREASES VENOUS OUTFLOW	7 times
REDUCES PERIPHERAL VASCULAR RESISTANCE	40%
INCREASES ARTERIAL INFLOW	4 times
REPERFUSION EDEMA PREVENTION	Yes
REPERFUSION EDEMA TREATMENT	Yes
PREVENTS DVT	Yes
ACCELERATES HEALING	Yes
HIGH PATIENT COMPLIANCE	Yes

Three, one hour sessions per day to prevent reperfusion edema or treat reperfusion edema until resorption is attained.

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

The Use of Transcutaneous Electrical Stimulation of the Calf in Patients Undergoing Infrainguinal Bypass Surgery. Maximilian Mifsud, MD and Kevin Cassar, MD; Annals of Vascular Surgery, 2015; 1-9.

A randomized controlled trial of electrostimulation effects on effusion, swelling, and pain recovery after anterior cruciate ligament reconstruction: a pilot study. Levent Ediz, MD, Mehmet Ceylan, MD, Ugur Turktas, MD, Ibrahim Yanmis, MD, and Ozcan Hiz, MD; Clinical Rehabilitation 26 (5) 413-422.

VasoCARE LLC

Physician's Written Order
VeinOPlus Vascular

6554 Florida Blvd, Suite 123
Baton Rouge, LA 70806
P 800-256-9979 **F** 866-455-5150
www.vasocare.com

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 (√) 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**