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

Here is the new solution

VEINOPLUS® Vascular

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases venous outflow</td>
<td>7 times</td>
</tr>
<tr>
<td>Reduces peripheral vascular resistance</td>
<td>40%</td>
</tr>
<tr>
<td>Increases arterial inflow</td>
<td>4 times</td>
</tr>
<tr>
<td>Reperfusion edema prevention</td>
<td>Yes</td>
</tr>
<tr>
<td>Reperfusion edema treatment</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevents DVT</td>
<td>Yes</td>
</tr>
<tr>
<td>Accelerates healing</td>
<td>Yes</td>
</tr>
<tr>
<td>High patient compliance</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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


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 Turkutas, MD, Ibrahim Yanmis, MD, and Ozcan Hiz, MD; Clinical Rehabilitation 26 (5) 413-422.
Physician’s Written Order

VeinOPlus Vascular

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
☐ VeinOPlus Vascular Electrodes (A4595)

Est length of need = _99_ months

Perform one hour session _____ times per day

☐ 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  Physician’s Printed Name  Date

(Stamps are not acceptable)

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