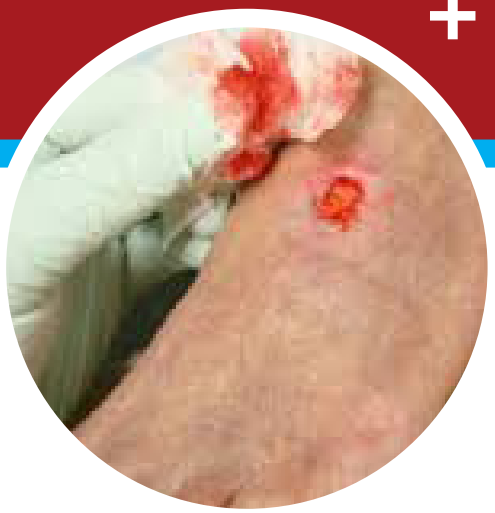
PERIPHERAL ARTERIAL DISEASE (PAD) + ARTERIAL FOOT ULCERS



Here is the new solution

VEINOPLUS®

Vascular

CLINICALLY PROVEN

- INCREASES VENOUS OUTFLOW **7** times
- DECREASES VASCULAR RESISTANCE **40%**
- INCREASES ARTERIAL INFLOW **4** times
- ACCELERATES HEALING **3** times
- COMPLIANCE **High**

Three, one hour sessions per day

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

Calf muscle stimulation with the VeinOPlus® device results in a significant increase in lower limb inflow without generating limb ischemia or pain in patients with peripheral artery disease. Pierre Abraham, MD, PhD, Victor Mateus, MD, Francois Bieuzen, PhD, Nafi Ouedraogo, MD; J. Vasc Surg 2013; 57:714-9.

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**