

Prescription/Rx for Ordering a Neuromuscular Electrical Stimulation Therapy Device (NMES)

Patient's Name: _____ DOB: _____ Phone: _____

☐ **VeinOPlus Vascular Device – E0745 – Stimulates calf muscles every second, similar to walking, and improves blood flow (venous outflow 7x and arterial inflow 5x).**

Check the corresponding diagnosis:

___ Disuse Muscle Atrophy (M62.561) Right Lower Limb.

___ Disuse Muscle Atrophy (M62.562) Left Lower Limb.

___ Chronic disease or injury leading to disuse muscle atrophy resulting from lack of exercise.

Other conditions leading to disuse muscle atrophy:

___ Claudication Limb Pain due to PAD.

___ Chronic edema due to Chronic Venous Insufficiency (CVI).

___ Diabetic Foot ulcer due to Arterial Insufficiency.

___ Restless Leg Syndrome (Movement Disorder) due to CVI.

___ Foot drop due to compression of personal nerve leads to disuse muscle atrophy.

To qualify, the nerve supply must be intact with the calf muscle. ☐ Yes ☐ No

Treatment Instructions: VeinOPlus

Perform one hour session _____ times per day

Contraindication - VeinOPlus must not be used by patients with implanted cardiac pacemakers.

FACE-TO-FACE ENCOUNTER CERTIFICATION

I certify this patient is under my care, has been seen within 6 months of this order, and supports the NCD policy set forth by CMS as it pertains to neuromuscular electrical stimulation (E0745) device.

Physician's Name: _____ Order Date: _____ Email: _____ Order Date: _____
Print

Address/City/State/Zip: _____

Phone: _____ Fax: _____

**PLEASE FAX: Prescription/Rx, Clinical Notes, and Demographic Sheet to 866-455-5150
or email: orders@vasocare.com**