TRANSCUTANEOUS NERVE STIMULATOR (TENS)
REQUEST FOR INFORMATION

PATIENT NAME: _____ SS#:_____ D.O.B.: _____

PLEASE HAVE THE PATIENT'S ATTENDING PHYSICIAN PROVIDE THE INFORMATION REQUESTED BELOW

1. Primary diagnosis necessitating use of TENS: _____

   a. Duration: 1-99 months(99=Lifetime)_____

2. Please describe associated symptoms: _____

   _____

   a. Date of onset: _____ ICD9 Code: _____

   b. Duration of symptoms: _____

   c. Description of symptoms (constant, intermittent, etc.): _____

   _____

3. a. What treatment has been rendered to date to address patient's diagnosis and symptoms? Surgery, Pain medications, Injections, etc?

Type of treatment:	Date:	Response:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

   b. Has patient tried Physical Therapy prior to TENS? _____

   c. Is patient currently being seen in Physical Therapy? _____

   Last date seen by Physical Therapy: _____ How many visits left: _____

   Response to Physical Therapy: _____

   _____

   _____

   _____

4. What other treatment is planned in addition to TENS? _____

   _____

   _____

5. Has patient had 30-day trial of TENS?
   ( ) No – Resubmit after trial completed.
   ( ) Yes – Please complete the following:

   a. Dates and duration of TENS trial: _____

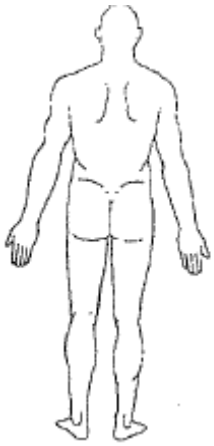
   b. Pain medication and dosage used prior to TENS trial: _____
   _____

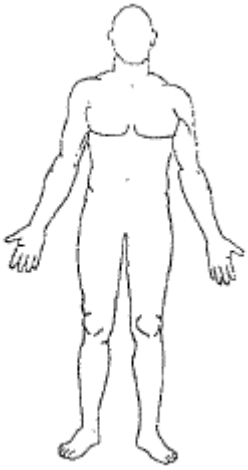
   c. Any medication changes since use of TENS began: _____
   _____

   d. What was the patient's level of compliance with the use of TENS during trial period? _____

   _____

   e. Number of leads used and why: _____
   _____





   f. Overall results of TENS trial: _____
   _____
   _____
   _____
   _____

_____ _____
M.D. Signature Date

_____
Telephone Number

_____
Physician's Address