PROFESSIONAL RECOMMENDATION

Healthcare provider/clinic information:

Name: ____________ Address: ____________

Phone: ____________ ____________

Email: ____________ ____________

PERSON TO BE COVERED BY THE PLAN

Name

Phone

Age

Address (optional)

RECOMMENDED CONTROLLER

Circle Controller

CONTROLLERS	TIME	SETTING
LS XP1	______	________
LS XP3	______	________
LS XP6	______	________

RECOMMENDED PAD

Circle Pad

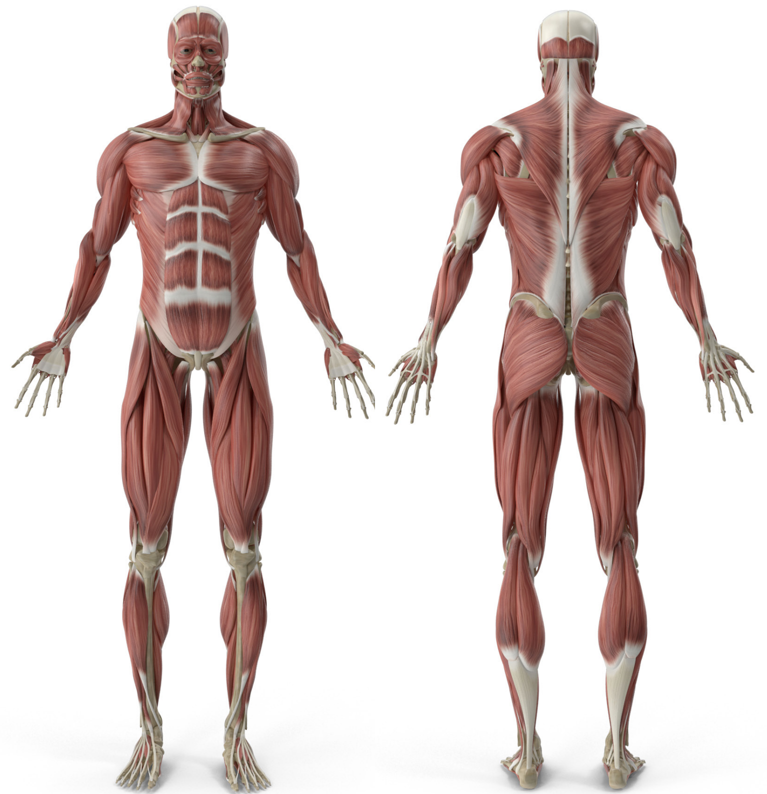
RED/INFRARED PAD	BODY PLACEMENT
LSG 264	____________
LSL 132	____________
LST 90	____________
LSH 155	____________
LSB 80	____________

BLUE/RED PAD	BODY PLACEMENT
LSF 104	____________

BLUE/INFRARED PAD	BODY PLACEMENT
LSG 264B	____________
LSL 132B	____________

AFFECTED AREA

(PLEASE CIRCLE BODY PARTS AFFECTED)



PROTOCOL / SPECIAL INSTRUCTIONS

Practitioner Signature ____________ Date ____________

PLEASE SUBMIT BY FAX TO: 1-866-290-6412