Physician's Prescription

Please complete the information below and FAX this signed form, relevant medical history/notes, and patient demographics to: Fax: 954-414-0861

PATIENT INFORMATION:

Name:_______________________Birth Date:____________ SS#: ____________________

City: ______________________ State:_____ Zip:______ Phone: ____________________

DIAGNOSIS and RELATED INFO: Date of Injury: ________________

Diagnosis:____ ICD 10 Code:_____________

Symptoms:____

Limitations:____

Pain Scale Level (0-No Pain - 10-Worse Pain Possible): (0-10) __________

Range of Motion: ☐ Active ☐ Passive ☐ Resistive

PRODUCT: NuroKor® MiTouch (Microcurrent+) Unit, electrode cables and patches, charging cables.

I am prescribing MiTouch which is an FDA cleared wearable device that produces microcurrent and e-stim wave forms for the treatment of inflammation and to reduce pain and accelerate the natural healing cascade for musculoskeletal related injuries. Microcurrent has been shown in multiple in vivo studies to increase ATP production which has been shown to induce macrophage proliferation, collagen production, perfusion and correspondingly increased oxygenated hemoglobin in the muscles. The availability of additional ATP has also been shown to accelerate the reduction of pain for the associated injury by reducing inflammation. NuroKor devices can also be used as an adjunct therapy pre-operatively, post-operatively, and during physical therapy and exercise to both strengthen and/or relax muscle groups. I certify that the MiTouch Microcurrent unit is medically indicated and in my opinion is reasonable and necessary tool help treat this patient's condition.

MiTouch Product Includes: MiTouch Microcurrent+ with KorOS5, electrode wires, USB charger cable, & 90-day pads (18 sets - *please circle one size for electrode pads)* **M** or **L** (Plus instruction sets and treatment guides).

Duration of Treatment: 2-4 Treatments per day; up to 2 Hours per day for up to 90-days

PHYSICIAN INFORMATION:

Physician's Signature: ______________________________________ Date: _______________

Physician Print Name:______________________________________

Physician Address: ____

City: ______________________ State:______ ZIP Code:__________ Phone: ____________________

NPI #:_________________________ License #:_________________________

FOR WORKERS COMP: Claim No.: ____________________

Carrier:______________________ Injury Date:___________ Adjuster Name: ____________________

City: ______________________ State:_____ Zip:_______ Phone: ____________________

NOTE: Please include all the appropriate **Medical Notes/LMN and Patient Demographics** with this Prescription when faxing to **954-414-0861**. We will need this information to obtain authorization.