

I control My Pain  
Po box 110487  
Brooklyn NY 11211  
Phone 1888 267 3631  
Fax 1888 718 9898

**PRESCRIPTION FORM –LETTER OF MEDICAL NECESSITY AND DOCTOR NOTES**

**Patient name:** \_\_\_\_\_

**Diagnosis (ICD-9) 1.** \_\_\_\_\_ **2.** \_\_\_\_\_ **3.** \_\_\_\_\_ **4.** \_\_\_\_\_

**Device Prescribed:**

\_\_\_\_ TENS / Supplies

**Symptoms:** \_\_\_\_\_

**Prognosis:** \_\_\_\_ Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Guarded

**Date First Diagnosed:** \_\_\_\_\_ **Date Last Seen:** \_\_\_\_\_

**Area (s) to be treated:** \_\_\_\_\_

**Previous Treatments Rendered:** \_\_\_\_ Manipulation \_\_\_\_ Massage Therapy \_\_\_\_ Surgery

\_\_\_\_ Heat/Ice Treatment \_\_\_\_ Physical Therapy \_\_\_\_ Medication: \_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_

I certify that the above prescribed equipment, supplies and accessories provided by I control My Pain, *are medically necessary as part of my treatment plan* for this patient's condition as stated above, I have initiated a trial use of the indicated equipment in my office and have found it to be effective. **This prescription is valid for one year from the date indicated below unless otherwise noted.**

\_\_\_\_\_  
**Physician's Signature** \_\_\_\_\_  
**Date**

(Please print below)

**Physician's Name:** \_\_\_\_\_ **License/ UPIN #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_