Verve Consulting Inc.

Prescription Form

Certificate of Medical Necessity

Patient Name:	
Address:	Phone #:
Date of Birth:	
Insurance Company:	
Policy/Claim #:	Member I.D #:

Prescription For: □ **OSTEOTRON IV (LIPUS) Bone Growth Stimulator 20 min/day for acute fracture and/or non-union (no substitutions)**

□ **ORTHOFIX Physio Stim/Spinal Stim/Cervical Stim (PEMF) Bone Growth Stimulator 3 hours/day for non-union 8 weeks post fracture/surgery (no substitutions)**

Diagnosis: _____

Comorbidity:

- ☐ Non-union
- ☐ Smoker
- ☐ Diabetes
- ☐ Revision
- ☐ Other_____
- ☐ High Risk (Complicated)
- ☐ Low Pain Tolerance
- ☐ Osteoporosis
- ☐ Infection

Prescribed by:

Signature: _____

Date: _____

Contraindications:

Osteotron IV: Over thoracic area in patients with cardiac pacemakers. Abdominal and pelvic regions during pregnancy. Patients with serious infection such as tuberculosis. Areas with open wound. Areas with thrombophlebitis. Orthofix: Use of this device is contraindicated where the individual has synovial pseudarthrosis.

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