

TRANSCUTANEOUS NERVE STIMULATOR (TENS)
REQUEST FOR INFORMATION

PATIENT NAME: _____ SS#: _____ B/D: _____

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, PT, etc? _____

- b. Response to treatment: _____
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