BIOMATION

Clinic:_____ Date:_____

Patients Name:_____ Telephone:_____

Address:_____

_____

Condition:_____

_____

Equipment Recommendation

9	**Elpha 2000** Muscle and Nerve Stimulator
9	**ELPHA II 3000** Muscle and Nerve Stimulator
9	**ELPHA II 1000** TENS
9	**Neuro-4** Trophic Stimulator
9	**TFS-290** Trophic Facial Stimulator
9	**Biosense** EMG Muscle Trainer
9	**NeuroMove NM900** EMG Controlled Muscle Stimulator
9	**GeniStim 330** HVPC Galvanic Stimulator
9	**IF-8000** Interferential Therapy Unit
9	_____
9	Purchase
9	Rental

Notes:_____

This recommendation identifies quality equipment deemed appropriate for this individual. The determination of such a recommendation is based upon the professional judgement of the therapist(s) involved in consultation with the client. The client agrees to accept the equipment described above upon delivery as authorized by his/her signature.

Authorized by:

_____
Client

Recommended by:

_____
Therapist's Signature

_____
Please Print Name

1 copy to Therapist
1 copy to Biomation
1 copy to Insurance Company
1 copy to Client

Supplier:

BIOMATION
335 Perth Street
P.O. Box 156
Almonte, Ontario K0A 1A0

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Toll Free: 1-888-667-2324
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E-Mail: sales@biomation.com
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