

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 **Biosense** EMG Muscle Trainer
- 9 **Neuromove NM900** EMG Controlled Muscle 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:

Recommended by:

Client

Therapist's Signature

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

Please Print Name

Supplier:

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