BIOMATION

Equipment Recommendation Form

Complete this form and fax to 613-256-5872

Clinic: ______________________________ Date: ____________________

Patient Name: ______________________________ Telephone: ____________________

Address: ____

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Condition: ____

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- ☐ Elpha II 3000 Muscle and Nerve Stimulator
- ☐ Elpha II 1000 TENS
- ☐ ActiStim A-2100 Trophic Muscle Stimulator
- ☐ ActiStim A-2100 Trophic Facial Stimulator
- ☐ Neuromove NM900 EMG Controlled Muscle Stimulator
- ☐ GeniStim 330 HVPC Galvanic Stimulator
- ☐ IF-8000 Interferential Therapy Unit
- ☐ Other ______________________________

Notes: ____

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- ☐ Purchase
- ☐ Rental

Authorized by: ____

Client

Recommended by: ____

Therapist's Signature

Please print name: ____

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.

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