QUINN MEDICAL

SLEEQ spinal • therapy • system

℞ Prescription Form

PATIENT NAME _____ **PROVIDER** _____

PHYSICIAN _____ **CONTACT** _____

NPI _____ **FAX** _____

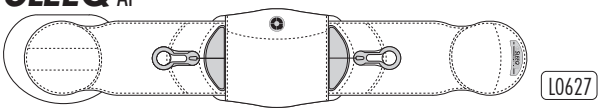
LOCATION _____ **PHONE** _____

PHONE _____ **ADDRESS** _____

CITY _____ **ST**_____ **ZIP**_____

Product

☐ **SLEEQ** AP



L0627

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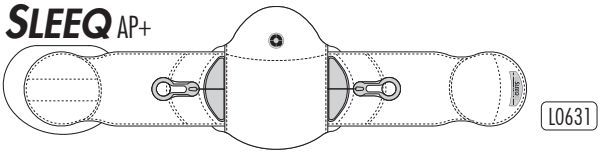

L0631

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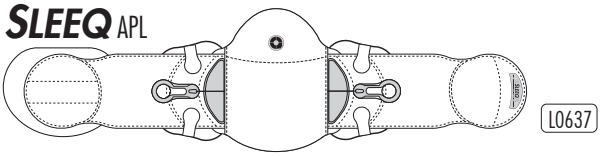

L0637

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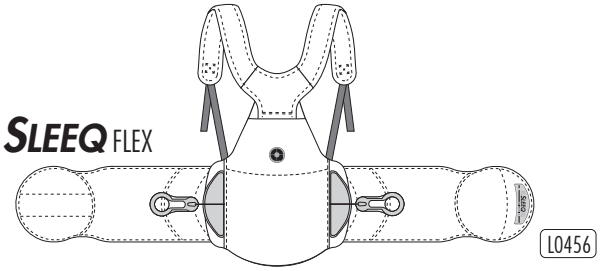

L0456

INDICATIONS RELATING TO MEDICAL NECESSITY

- ☐ Manage Pain
- ☐ Relax Muscle Spasms
- ☐ Reduce Instability
- ☐ Limit Range of Motion (ROM)
- ☐ Improve ADL's/Functioning
- ☐ Protect Surgical Repair/Soft Tissue
- ☐ Non-union Fracture
- ☐ Spinal Fusion

OTHER COMMENTS

I, the undersigned, confirm the order for the above-named patient. I also certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of this patient's condition.

PHYSICIAN/PROVIDER SIGNATURE _____ **DATE** _____

Dispense as Written. No Substitutions.