

**Sonic Technology Products, Inc.**

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**PHYSICIAN’S PRESCRIPTION – STATEMENT OF MEDICAL NECESSITY**

Name of Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_ eMail: \_\_\_\_\_

**DIAGNOSIS CODES:**

**Reason for Equipment:**

- Reduction of Pain
- Increase Range of Motion
- Other \_\_\_\_\_
- Increase Function Mobility
- Reduce Muscle Spasm
- Stimulus Soft Tissue Healing
- Decrease Edema & Inflammation

- Prescription:  **Sonic TENS (FDA 510K # K071624)**  
 Transcutaneous Electrical Nerve Stimulator **Model # SON-TENS**
- Sonic MS (FDA 510K # K071320)**  
 Muscle Stimulator **Model # SON-MS**

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City/Sate/Zip: \_\_\_\_\_

Phone Number (\_\_\_\_)\_\_\_\_\_ eMail: \_\_\_\_\_

I the undersigned certify that the above equipment is medically necessary for this patient. In my opinion the equipment is both reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient’s condition and is NOT prescribed as “CONVENIENCE” equipment.

\_\_\_\_\_  
Physician’s Signature

\_\_\_\_\_  
Date Authorized