Fill in the Rx template directly from your computer or print and complete by hand
Send completed and signed prescriptions to rx@neurolutions.com or fax to (323) 300-2410

Prescription Form

PATIENT

FIRST NAME ______________________ LAST NAME ______________________

ADDRESS ______________________ CITY ______________________

STATE ______________ ZIP ______________

ICD-10 CODE ______________________ BIRTHDATE ______ / ______ / ______
MM DD YYYY

PRESCRIPTION

PRODUCT

IpsiHand Upper Extremity Rehabilitation System

LEFT OR RIGHT SIDE

Left

Right

PRESCRIPTION DATE

______ / ______ / ______
MM DD YYYY

HEALTH CARE PRACTITIONER

FIRST NAME ______________________ LAST NAME ______________________

NPI NUMBER ______________________
NATIONAL PROVIDER IDENTIFIER 10-DIGIT NUMBER

EMAIL ______________________

ADDRESS ______________________ CITY ______________________

STATE ______________ ZIP ______________ PHONE ______________

DATE

______ / ______ / ______
MM DD YYYY

____
HCP SIGNATURE

Neurolutions