

Physician's Prescription

Please **PRINT CLEARLY** and complete the information below. Submit this form along with relevant medical notes and treatment history to orders@samrecover.com or Fax: 888-202-9831

PATIENT INFORMATION:	
Patient Name: _____	Date of Birth: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Email: _____	Employer: _____ Phone: _____

Diagnosis: _____	ICD 10 Code: _____
Symptoms: _____	
Limitations: _____	
Pain Level: <input type="checkbox"/> No Pain <input type="checkbox"/> Mild Pain <input type="checkbox"/> Moderate Pain <input type="checkbox"/> Severe Pain <input type="checkbox"/> Worst Pain Possible	
Range of Motion: <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Resistive	

PRODUCT: sam[®] 2.0 (Sustained Acoustic Medicine) Unit and Gel Capture Patches

I am prescribing sam[®] 2.0 which is the only FDA cleared wearable Low Intensity Ultrasound for multi-hour treatment to reduce pain (without prescription pain medication) and accelerate the healing for musculoskeletal related injuries. sam[®] has been clinically shown to increase Collagen Lay-down, increase Oxygenated Hemoglobin in the muscles and increase multi-hour blood-flow to accelerate the recovery and reduction of pain for the associated injury. sam[®] provides up to 4-hours treatment per day at work or home. sam[®] is not Therapeutic Ultrasound which is only used for 5-6 minutes in a clinic and does not accelerate healing or reduce pain. I certify that the sam[®] 2.0 unit is medically indicated and in my opinion is reasonable and necessary to treat this patient's condition.

sam[®] 2.0 Product Includes: Dual Applicators; Power Controller; Charger; 1 Tube of Coupling Gel, and a Quick-Start Guide. In addition, 60 days of treatment packs of sam[®] 2.0 Patches (120 pieces total) are required for treatment.

Duration of Treatment: 1 Treatment per day; up to 4 Hours per day. **Length of Need:** _____ (99 = Lifetime)

PHYSICIAN'S INFORMATION:	
Physician's Signature: _____	Date: _____
Physician Print Name: _____	
Physician Address: _____	
City: _____	State: _____ ZIP Code: _____ Phone: _____
NPI #: _____	License #: _____

NOTE: Dispense as written/noted – no substitutions allowed. Authorization cannot be obtained without all the necessary information. Thank you in advance.