Rehabilicare®
Bringing your care home.
A Division of Compex Technologies, Inc.
P. O. Box 30244
Tampa, FL 33630-3244
(800) 343-0488
Corporate Fax: 1-800-272-6458

SpinaLogic® Bone Growth Stimulator Prescription

PATIENT NAME _____ SSN _____

DOB _____ PHONE _____

MEDICAL SUMMARY

ICD9 CODE(S) _____

Primary Diagnosis

- ☐ Degenerative Disc Disease
- ☐ Internal Disk Disruption
- ☐ Herniated Nucleus Pulposis
- ☐ Lumbar Instability
- ☐ Low Back Pain
- ☐ Other _____
- ☐ Scoliosis
- ☐ Spondylolisthesis/Grade _____
- ☐ Spinal Stenosis
- ☐ Radiculapathy

Planned Procedure: _____

Date _____

Fusion Surgery _____ To _____

Other _____

Prior Procedures	Date	Levels
☐ Fusion Surgery	___ / ___ / ___	_____ to _____
☐ Discectomy	___ / ___ / ___	_____ to _____
☐ Laminectomy	___ / ___ / ___	_____ to _____
☐ Other	___ / ___ / ___	_____ to _____

Identify Other _____

Check All That Apply

- ☐ Multi Level Fusion
- ☐ Tobacco Use (___ppd)
- ☐ Alcohol Use
- ☐ Previous Back Surgery
- ☐ Identify Other _____
- ☐ Obesity
- ☐ Arthritis
- ☐ Autograft
- ☐ Stenosis
- ☐ Diabetes
- ☐ Allograft
- ☐ Osteoporosis
- ☐ Mixed Graft
- ☐ Failed Fusion
- ☐ Spondylolisthesis

PLEASE READ AND SIGN BELOW: I understand the Food and Drug Administration has approved the SpinaLogic Bone Growth Stimulator (SpinaLogic) to the use as an adjunct treatment to primary lumbar fusion surgery for one or two levels. I acknowledge that Rehabilicare, has not promoted SpinaLogic to me for any other use or otherwise encouraged me to order it for any other use. I specifically desire to order SpinaLogic, which is available from Rehabilicare, so that I may treat the patient in question according to my informed medical judgment.

☐ DISPENSE AS WRITTEN (no substitutions without authorization from prescribing physician)

X _____
PHYSICIAN'S SIGNATURE DATE UPIN#

_____
REPRESENTATIVE/DISTRIBUTOR NAME/TITLE (PRINT) SIGNATURE DATE

_____
PAPERWORK SPECIALIST NAME (PRINT)

Please retain a copy for your records.