CALMARx PAIN RELIEF THERAPY

provided by
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Patient Referral Form

Patient Referral Form

Patient Information

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____

Referring Physician Information

Name:_____

Office Address:_____

City, State, Zip:_____

Phone:_____

Reason for Referral:

- ☐ Back Pain – Sciatic Pain, Failed Back Syndromes, Failed Back Surgery Syndromes
- ☐ Neuropathic Pain Syndromes, Mono and Polyneuropathy
- ☐ Post Herpetic Neuropathy
- ☐ Oncologic Pain Including Visceral Pains
- ☐ Other: (please explain)_____

Patient Medical History & Medications:_____

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Note: Contraindications:

DO NOT use on patients with metal implants such as pacemakers, automatic defibrillators, aneurysm clips, vena cava clips and skull plate.

However, the MC-5A device CAN BE USED on patients with metal implants such as total knee, hip, shoulder, and other joint replacements as well as on patients with implanted pins, clips, screws, plates and cages used for orthopedic repair.