



NEURO-FITNESS LLC

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## CES Ultra Prescription Form

# R<sub>x</sub>

Cranial electrotherapy stimulator (CES Ultra)

Physician/Healthcare Provider: Name \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Medical Necessity:

For \_\_\_\_\_ Anxiety \_\_\_\_\_ Depression \_\_\_\_\_ Insomnia

Dispense as written

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*NOTE: If you are ordering a CES Ultra Kit with a shipping destination outside the US, no prescription form is required.*