CES Ultra Prescription Form

Rx

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.