



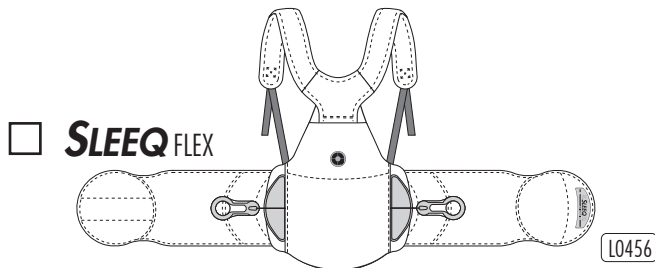
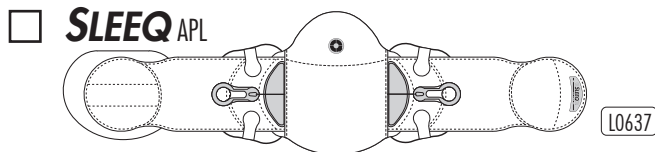
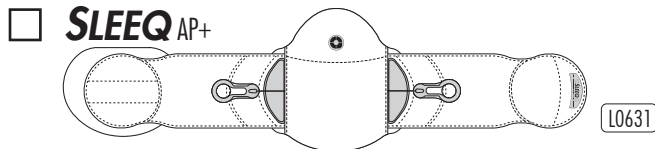
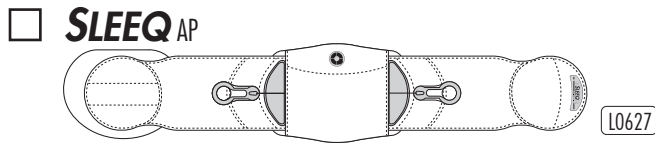
QUINN MEDICAL

SLEEQ
spinal • therapy • system

Rx Prescription Form

PATIENT NAME _____	PROVIDER _____
PHYSICIAN _____	CONTACT _____
NPI _____	FAX _____
LOCATION _____	PHONE _____
PHONE _____	ADDRESS _____
	CITY _____ ST _____ ZIP _____

Product



INDICATIONS RELATING TO MEDICAL NECESSITY

- Manage Pain
- Relax Muscle Spasms
- Reduce Instability
- Limit Range of Motion (ROM)
- Improve ADL's/Functioning
- Protect Surgical Repair/Soft Tissue
- Non-union Fracture
- Spinal Fusion

OTHER COMMENTS

I, the undersigned, confirm the order for the above-named patient. I also certify that the prescribed treatment is medically reasonable and necessary in reference to accepted standards of medical practice within the community for treatment of this patient's condition.

PHYSICIAN/PROVIDER SIGNATURE _____ **DATE** _____

Dispense as Written. No Substitutions.