

Vacuum Erection System Prescription

Patient Information

Patient Name: _____

Phone: _____ Date of birth: _____

Product Information _____

_____ Piston pump II _____ Response _____ Touch II

Primary Diagnosis: _____ 607.84 Organic Impotence

Secondary Diagnosis: 250.01 Insulin Dependent Diabetes Mellitus

I hereby certify the medical necessity of this item for this patient. The foregoing information is true, accurate and complete and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Please Print

Physician Name: _____

Physician Signature: _____

Attending: _____ Consulting: _____ Other: _____

Phone: _____ Upin: _____ Date: _____