



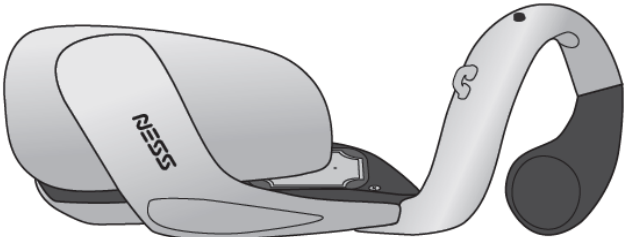
REQUEST FOR TRIAL & FITTING

PATIENT NAME: _____

PHONE: _____ WORK/CELL: _____

ADDRESS: _____ CITY: _____

DIAGNOSIS: _____

	<p>Please indicate which device you are interested in trialing.</p>
<p><input type="checkbox"/> L300 Foot Drop System</p> 	<p><input type="checkbox"/> H200 Wireless Hand Rehabilitation System</p> 

NOTE: Patients with foot drop as a result of diabetic neuropathy or failed back surgery may not be candidates for FES device, but an EMG confirming eligibility may be required.

SIGNATURE: _____ DATE: _____

Please Fax your referral to the appropriate site above.

IMPORTANT NOTICE ON CONFIDENTIALITY:

Thank you for your referral to the ATC. The contents of this fax transmission contain confidential information intended for the person(s) named above. Any copying, disclosure or distribution is strictly prohibited. In the event that this fax was received in error, please notify us immediately by phone and destroy this document.