Quell
Fibromyalgia

# Quell® Fibromyalgia Prescription

**Patient Information:**

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

E-Mail: _____ Cell Phone (optional): _____

**Medication Information:** **DIRECTIONS REQUIRED**

Prescription Device: **Quell Fibromyalgia** (Quell device, leg band, and 1-month electrode supply)

Directions: ☐ PRN ☐ Other directions: _____

_____

**Prescriber Information**: **SIGNATURE REQUIRED**

Name: _____ **NPI Number:** _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip code: _____

**Prescriber Signature:** _____

**Additional Comments or Instructions:** _____

****ALL FIELDS ARE REQUIRED FOR A VALID PRESCRIPTION****
**Fax Form to (859) 525-0095**

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