Quell Fibromyalgia

Prescription Form

You can fax the completed form to 855-647-1320 or email it to orders@electrocore.com.

PATIENT INFORMATION		
Patient's Full Name:	Patient's Birthdate:/ /	Conf.
Address:		
City: State:	Zip Code:	(b) 100
Phone Number:	Email:	Starter Kit Includes:
ADDITIONAL COMMENTS OR INSTRUCTIONS	i:	 1 Quell Fibromyalgia Device 1 Quell Standard Size Band 4 Standard Electrode Packs (8 Electrodes) 1 Charger 1 Charger Cable
MEDICATION INFORMATION		
Prescription Device Name: QUELL FIBROMYALGIA STARTER KIT Number: QE-FMG-4 Quantity: 1		
DIRECTIONS REQUIRED: O As Needed O Other Directions:		
PRESCRIBER INFORMATION		
		DEA, NPI, or License #:
Practice Name:		
Address:		
City:	State:	Zip:
Phone Number:	Email:	

ALL FIELDS ARE REQUIRED FOR A VALID PRESCRIPTION. FAX FORM TO 855-647-1320.

For questions about prescribing, clinical use, or training related to Quell Fibromyalgia, call electroCore at 888-903-2673 or email customerservice@electrocore.com.

By completing and submitting this form, I represent that I am a licensed US health care professional qualified to treat patients who may benefit from use of Quell Fibromyalgia, and I authorize electroCore to enter the information I have provided into a database that will be publicly accessible at our website by persons who may contact me seeking medical care. l agree that electroCore, its agents, subcontractors, affiliates, or third parties under contract with them may contact me from time to time by telephone, mail, or email to provide information about products or services that may be of interest to me. I have a right to access and verification to my information. I also have a right to opt-out of the database at any time. I may "opt-out" or change my information at any time by emailing info@electrocore.com. This statement may be updated from time to time. Inclusion in the database is not intended to be and should not be construed as an inducement or encouragement for the referral of patients or the use of particular products, electroCore reserves the right not to include any or all information in the physician finder database, or to remove or disable any listing in the physical finder database at any time for any reason without approval or notice.



Health Care Provider's Signature:

Date: