RelieVRx

Customer Support: 1 (844) 728-4487
Fax Completed Forms: 1 (877) 552-1753
www.RelieVRx.com

Complete this form and fax with the patient's **medical chart face sheet** and **visit notes** to: 1 (877) 552-1753.

Patient Information

Patient First Name _____ **Patient Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Date of Birth (MM/DD/YYYY) _____ **Gender:** ☐ Female ☐ Male ☐ Non-binary

Phone Number _____ **Email** _____

Emergency Contact _____ **Emergency Contact Phone:** _____

Prescriber Information

Prescriber First Name _____ **Prescriber Last Name** _____

NPI Number _____ **Prescriber Email** _____

Location Address _____

City _____ **State** _____ **Zip Code** _____

Phone Number _____ **Fax Number** _____

Prescription

Diagnosis Code: (Select All That Apply)
☐ **M54.50** (Low Back Pain,Unspecified)
☐ **M54.51** (Vertebrogenic Low Back Pain)
☐ **M54.59** (Other Low Back Pain)
☐ Other _____

Supporting Clinical Symptoms (Check all that apply)

☐ Diagnosis of chronic lower back pain (CLBP), documented in the clinical notes or below:
- ☐ Clinical Evaluation
- ☐ Imaging showing degenerative changes or other chronic pathology
- ☐ Documented pain scale rating ≥4 on a 10-point scale despite conservative treatments

☐ Prior and Current treatments (failed or contraindicated), documented in the clinical notes or below (Select all that apply):
- ☐ Physical Therapy
- ☐ Opioid Pain Management
- ☐ Injection Therapy
- ☐ Non-Opioid Pain Management
- ☐ Radiofrequency Ablation
- ☐ Other:_____

☐ RelieVRx is prescribed for in-home use under clinician supervision

☐ Patient is capable of using VR-based self-guided therapy

Prescribing Information

Item To Dispense: RelieVRx. Dispense: One VR Device. Dispense As Written. Length Of Need: 3 Months. Frequency Of Use: 1 Session Daily.

Prescriber Authorization

I certify that the patient's record contains supporting documentation which substantiates the utilization and medical necessity of RelieVRx.
I understand the indications for use and associated warnings and precautions of the RelieVRx product I have prescribed herein.

Prescriber Signature _____ **Date** _____