



Prescription Device Request Form

Phone: (866) 385-6442

Fax: (914) 533-1105

Email: sales@visualfootcare.com

Address: The Kennedy Center
39 Lindeman Drive
Trumbull, CT 06611

Patients: Please have your doctor complete this form. Prescription drug and device requests can **only** be submitted by a licensed physician. We do not accept any insurance.

Please note: Orders will be processed within 4-7 business days after we receive the faxed prescription from your doctor. Therefore, when placing your order, you should expect device to arrive no earlier than two weeks after you place your order. Please plan accordingly.

Doctors: Your patient would like to receive this prescription from Visual Footcare Technologies, LLC. We are requesting an approval of this prescription from you. Please take a moment to complete the requested information in the form found on the following page. Completing all of the fields on the form helps to ensure timely order processing for your patients. You can fax your patients' prescriptions to us at the number listed on the top of this form.

1. Fill in both Prescriber and Patient information.
2. Make sure your office's secure fax number is listed correctly. (*A secure fax location is defined as an area where patient information is kept confidential.*)
3. Tape the prescription from your script pad in the space indicated below. Please ensure that the following information is included in the prescription:
 - Patient's first and last name
 - Patient's date of birth
 - Date of prescription
 - Identify prescription for one or more TempStat units.
 - Prescriber's signature
4. Fax the completed form **without** a cover sheet to (866)385-6442

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PRESCRIPTION FAX FORM

Complete this form and fax without a cover sheet to Visual Footcare Technologies, LLC at:
(866) 385-6442

PRESCRIBER INFORMATION:	PATIENT INFORMATION:
Name: Address: City: State: Zip: Phone #: Fax #:	Name: Date of Birth: Address: City: State: Zip: Phone #:

TAPE PRESCRIPTION HERE

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