

**PRESCRIBER INFORMATION**

First Name\* \_\_\_\_\_  
 Last Name\* \_\_\_\_\_ (MD/DO/CRNP/PA)  
 NPI#\* \_\_\_\_\_  
 Practice Name/Institution\* \_\_\_\_\_  
 Office Contact Person\* \_\_\_\_\_  
 Office Contact Phone\* \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Email\* \_\_\_\_\_

**PATIENT INFORMATION**

First Name\* \_\_\_\_\_  
 Last Name\* \_\_\_\_\_ DOB\* \_\_\_\_\_  
 Secondary Contact \_\_\_\_\_  Can Contact  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Phone\* \_\_\_\_\_  
 Email\* \_\_\_\_\_ Gender\* M / F  
 Payer Name\*\* \_\_\_\_\_  
 Payer Phone\*\* \_\_\_\_\_  
 Payer ID\*\* \_\_\_\_\_

\* Required Fields \*\*Not Required for VA Patients

Cala Trio Customer Success will contact your patient to discuss payment options and provide product support.

**INDICATIONS FOR USE**

To aid in the transient relief of hand tremors in the treated hand following stimulation in adults with essential tremor (ET).

Caution: Federal law restricts this device to sale by or on the order of a physician.

**CONTRAINDICATIONS**

Cala Trio Therapy System should NOT be used:

- by patients with an implanted electrical medical device, such as a pacemaker, defibrillator, or deep brain stimulator.
- by patients that have suspected or diagnosed epilepsy or other seizure disorder.
- by patients who are pregnant.
- on swollen, infected, inflamed areas, or skin eruptions, open wounds, or cancerous lesions.

**PROVIDER AUTHORIZATION**

I hereby attest that this order accurately reflects signatures/notations that I made in my capacity as the above-mentioned patient's provider. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Prescriber's Signature X \_\_\_\_\_ Date: \_\_\_\_\_

To ensure measuring accuracy please print on 8.5" x 11" paper and confirm printer calibrations are properly aligned

**MEDICAL NECESSITY**

For each task listed, circle the number that best describes how your patient is able to perform the activity.

	Able to do activity without difficulty	Able to do activity with little effort	Able to do activity with a lot of effort	Cannot do without assistance
Use a spoon to drink soup	1	2	3	4
Hold a cup of tea or coffee	1	2	3	4
Write a letter	1	2	3	4

Has the patient previously tried medication for essential tremor? Yes  No

**PRESCRIBING INFORMATION**

Diagnosis: ICD-10 Code:

G25.000  Other \_\_\_\_\_

*Essential tremor*

Rx - Cala Trio Therapy (12 months)

1 Cala™ Stimulator, 4 Cala™ Bands

To expedite fulfillment, please complete the following parameters

Cala Trio™ is designed to stimulate nerves in the left OR right wrist. The device is NOT interchangeable between the left and right hand.

Right Hand Device  Left Hand Device

Measure the patient's wrist circumference proximal to the head of the ulna to determine band size:

Small  Medium  Large  
 13.6 - 16.4cm      16.5 - 18.4cm      18.5 - 20.4cm

The "Tremor Task" is a postural hold that helps characterize the patient's tremor. Most patients use the outstretched postural hold. Please note if the patient should use an alternative postural hold.

Outstretched  Wing Beating

