

Bioness NESS H200[®] Hand Rehabilitation System

The NESS H200[®] hand rehab system allows your patients to open and close their hands with less difficulty; grasp and release objects. Your patients may be able to do all this—and more—thanks to the NESS H200 Hand Rehabilitation System. The NESS H200 has a range of benefits for your patients—all designed to improve the use of the hand.

For function.

For freedom.

For life.



Advanced Physical Therapy Center

The therapist you choose does make a difference



Bioness NESS H200[®] Hand Rehabilitation System

A range of benefits for many

The NESS H200 may help your patients regain function in the hand and wrist if the condition is due to:

- Stroke
- Traumatic brain injury
- Spinal cord injury
- Certain neurological disorders

Added benefits

Beyond helping movement in the hand and wrist, the NESS H200 may also:

- Improve active hand range of motion and function
- Reeducate muscles to function without the system
- Reduce muscle spasms
- Increase local blood circulation
- Prevent muscle loss (atrophy)

Two advanced components keep it simple

With just one hand, your patient can put on, operate, and remove the NESS H200.

1. Lightweight, comfortable Orthosis is custom positioned to the forearm and hand to ensure that your patients get precisely the stimulation they need.
2. Hand held Control Unit sends electrical pulses to the muscles that control hand and wrist function. As the healthcare professional, you customize the settings for the stimulation that's right for the patient.

"... THE H200 HAS HELPED ME TO BECOME MORE CONFIDENT... JUST LAST NIGHT I WAS ABLE TO PICK UP AN APPLE..."

JOE G., 32 YEAR STROKE SURVIVOR

Designed to Improve the Use of the Hand*

The NESS H200 is a state-of-the-art functional electrical stimulation (FES) system that uses low-level stimulation to help the hand open and close. Customizable stimulation programs may help the patient perform daily activities and also reeducate the muscles over time.

*Individual results vary.



Grand Blanc.....810-695-8700..... 10809 S. Saginaw Street
Clio.....810-687-8700.....303 S. Mill Street
Flint.....810-732-8400.....G-2241 S. Linden Rd, Suite A
Hartland.....810-632-8700.....11182 Highland Road

Davison.....810-412-5100.....2138 Fairway Drive
Goodrich.....810-636-8700.....7477 S. State Rd, Suite B
Clarkston.....248-620-4260.....6167 White Lake Road, Suite 1
www.AdvancedPhysicalTherapy.com

IMPORTANT

Bring this prescription and any HMO referral, Auto or Worker's Comp authorizations on your first day.



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The therapist you choose does make a difference

PRESCRIPTION

MEDICARE CERTIFICATION/RECERTIFICATION

Grand Blanc (810) 695-8700
Fax (810) 695-7946

Clio (810) 687-8700
Fax (810) 687-8724

Flint (810) 732-8400
Fax (810) 732-4075

Hartland (810) 632-8700
Fax (810) 632-5850

Goodrich (810) 636-8700
Fax (810) 636-8702

Davison (810) 412-5100
Fax (810) 412-5106

Clarkston (248) 620-4260
Fax (248) 620-4239

Date _____ Patient Phone Number _____

Name _____

Diagnosis _____

Precautions _____

Physical / Occupational / Hand Therapy

- | | | |
|---|---|---|
| <input type="checkbox"/> Evaluate and Treat per Care Plan | <input type="checkbox"/> Sportsmetrics | <input type="checkbox"/> Paraffin Bath |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Manual Techniques | <input type="checkbox"/> Fluidotherapy |
| <input type="checkbox"/> Self Care Education | <input type="checkbox"/> Graston Technique | <input type="checkbox"/> Pinch/Grip strengthening |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Scar massage |
| <input type="checkbox"/> Passive ROM | <input type="checkbox"/> Myofascial Release | <input type="checkbox"/> Desensitization |
| <input type="checkbox"/> Active-assisted ROM | <input type="checkbox"/> Soft Tissue Massage | <input type="checkbox"/> Orthotic Fabrication: _____ |
| <input type="checkbox"/> Active ROM | <input type="checkbox"/> Ultrasound/Phonophoresis | <input type="checkbox"/> Tendon Repair Protocol _____ |
| <input type="checkbox"/> Progressive Resistive Exercise | <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Therapeutic Activities _____ |
| <input type="checkbox"/> Sports Rehab | <input type="checkbox"/> Light/Laser Therapy | <input type="checkbox"/> ADL Activities _____ |
| <input type="checkbox"/> Neuromuscular Re-Education | <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> TMJ Rehabilitation |
| <input type="checkbox"/> Vestibular Rehab | <input type="checkbox"/> Cervical Traction | <input type="checkbox"/> Lymphedema Treatment |
| <input type="checkbox"/> LSVT Big Therapy | <input type="checkbox"/> Pelvic Traction | <input type="checkbox"/> Functional Capacity Evaluation |
| <input type="checkbox"/> Gait and Balance Training | <input type="checkbox"/> TENS | <input type="checkbox"/> Work Reconditioning/Hardening |
| WB Status: _____ | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Return to Work Assessment |
| <input type="checkbox"/> Advanced Stabilization | <input type="checkbox"/> Contrast Bath/Whirlpool | <input type="checkbox"/> Disability Testing |
| <input type="checkbox"/> Med X Testing/Rehab | <input type="checkbox"/> Bioness | <input type="checkbox"/> Ergonomic Assessment |
| <input type="checkbox"/> Pediatric Transformers Program | <input type="checkbox"/> Women's Health | |

Comments/Goals _____

3 x Weekly 2 x Weekly Daily **Number of visits** _____
for _____ **weeks** _____ **months**

I certify / recertify that I have examined the patient and physical and/or occupational therapy is necessary, and that services will be furnished while the patient is under my care, and that the plan is established and will be reviewed every ninety (90) days or more often if the patient's condition requires. I estimate that these services will be needed for 90 days.

R _____

Physician Signature

Date

PHYSICAL AND OCCUPATIONAL THERAPY APPOINTMENT INFORMATION: When you receive this prescription please call to set up your first appointment. Bring this prescription, all insurance information such as insurance cards, forms, HMO referrals, worker's compensation or auto insurance claim numbers. Check with your insurance company if you are unsure of your physical and occupational therapy benefits. Wear or bring comfortable clothing so that the area to receive treatment can be easily exposed. Hospital gowns will be provided when needed. If it is necessary to cancel and reschedule, please try to notify us 1 day in advance.

We look forward to serving your rehabilitation needs.

For further information, you may contact us by phone or to speed your registration process, fill out / print forms online at www.advancedphysicaltherapy.com under **NEW PATIENTS**.