

TENs Referral Form

NHS Number:.....

Name:

DOB:

Address:

..... Post Code:

Tel No:

GP:

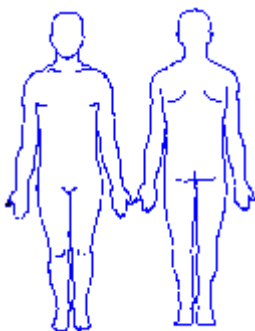
Diagnosis

Screened for Contra Indications

	No		No		No
Pacemaker		Broken skin		Allergies	
Pregnant		Skin irritation		Hypersensitivities	
Loss of skin sensation		Epilepsy			

Significant PMH

Medication



Referrers Signature:

Date of Referral:

Mark position for electrodes