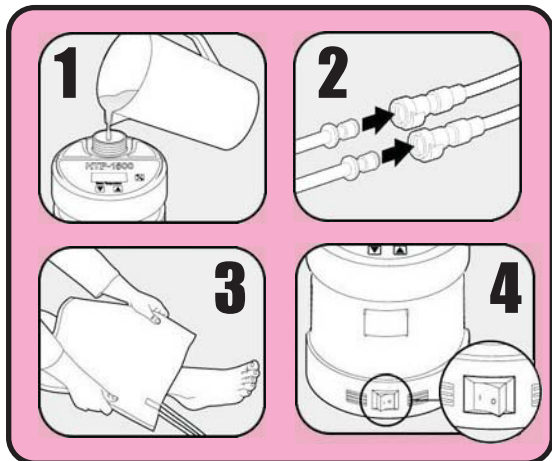


## Pain Relief & Increased Circulation / Perfusion

The HTP-1500 is a localized heat therapy system. It uses a flexible water circulating pad to deliver controlled temperature therapy to any area of the body. The pump is microprocessor controlled and has built in safety features to prevent over-heating. The HTP-1500 is pre-set to a safe and effective temperature of 105°F, but can be adjusted if needed. In addition, heat therapy stimulates thermoreceptors in tissue signaling comfort to the brain and reducing pain. Therefore, increased blood flow, improved oxygen delivery and pain relief, are the clinical results of continuous low level heat therapy; and there are no side effects. Patients should however check skin condition frequently, especially if they have no feeling in the treatment area.

## Safe, Effective & Easy



**Medicare Approved**

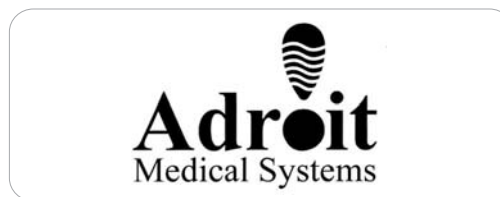
# Heat Therapy Medicare E0217 FDA 510k Approved

Unlike electric heating pads, the HTP-1500 is FDA 510k approved for continuous use *and can be used even while the patient is asleep*. Approved for use at home, the HTP-1500 uses TAP WATER to deliver accurately controlled temperature therapy where it hurts, or where circulation needs a boost. The HTP-1500 pad can be folded, wrapped, rolled, sat on, slept on, and applied anywhere to the body!



**Safe for use  
with all ages!**

Read patient & doctor testimonies at  
[adroitmedical.com/testimonials.htm](http://adroitmedical.com/testimonials.htm)



800-267-6077 [adroitmedical.com](http://adroitmedical.com)

# Pain Relief

Without The Drugs



**HTP-1500 Heat Therapy System**

Arthritis  
Chronic Pain  
Diabetic Safe



Available by prescription only.

# Detailed Written Order: E0217 Pump Pad Combo and E0249\* Replacement Pad \*Not with initial order

*Item description: FDA 510k Approved continuous low-level heat therapy system with replacement pad as needed.*

**Adroit Heat Pump**  
Serial No. (Optional)

Initial Date of Medical Necessity: \_\_\_\_\_

Serial No. recommended

Patient Name: \_\_\_\_\_ Medicare # \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Length of Need: \_\_\_\_\_ (99 = lifetime)

Continuous use:  or Hours of use: \_\_\_\_\_ X per day \_\_\_\_\_

The physician certifies the following:

A. The patient suffers from a condition(s) that requires the use of an HTP-1500 Heat Therapy System: Reference ICD9 Code(s) \_\_\_\_\_

B. The patient's condition is chronic (minimum 3 months suffering).

C. Previous medication(s) and or therapy treatments have been: medications, and/or physical therapy, and/or an electric heating pad.

Explain: \_\_\_\_\_

D. The following contraindications are present that prohibit the use of electric heating pads, hot packs or pain medications:

- Drug interactions  Restricted pain medications due to medical condition (i.e., stroke)  
 Oxygen rich environment  Patient consciousness or safety awareness

E. The HTP-1500 Heat Therapy System provides therapy that cannot be achieved by electric heating pads or hot packs.

F. The HTP-1500 Heat Therapy System delivers hours and or overnight continuous temperature therapy necessary for treatment of the patient.

G. The HTP-1500 Heat Therapy System is safer to use and reduces the risk of injury compared with electric heating pads or hot packs.

Description of treatment provided by the HTP-1500 for the above patient (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Improve circulation            | <input type="checkbox"/> Increase blood oxygen perfusion (PI) | <input type="checkbox"/> Drug free pain relief |
| <input type="checkbox"/> Reduce pharmaceutical usage    | <input type="checkbox"/> Amputation prevention                | <input type="checkbox"/> Use while sleeping    |
| <input type="checkbox"/> Increase joint range of motion | <input type="checkbox"/> Hypertension / High blood pressure   | <input type="checkbox"/> Relax muscles         |
| <input type="checkbox"/> Wound therapy                  | <input type="checkbox"/> Chronic pain                         | <input type="checkbox"/> Nerve damage          |

Comments: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (Printed): \_\_\_\_\_ NPI#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_