

Recommendation for transcutaneous vagus nerve stimulation (t-VNS) with NEMOS[®]

I hereby recommend

Mr./Ms. _____ ,

Address _____ ,

Street, Nr. ZIP City

Phone E-mail

born _____ , with the

diagnosis _____

for a treatment attempt with transcutaneous vagus nerve stimulation using NEMOS[®]. The transcutaneous vagus nerve stimulation with NEMOS[®] has the European certification (CE) for the treatment of epilepsies.

Name (Doctor) _____

Address (Doctor) _____

Consent of Doctor

I hereby allow tVNS Technologies GmbH, Ebrardstr. 31, 91054 Erlangen as responsible authority to process the above data to determine if the patient is suitable for therapy with the NEMOS[®] device.

Date

Signature and stamp (Doctor)

Consent of Patient

I hereby allow tVNS Technologies GmbH, Ebrardstr. 31, 91054 Erlangen as responsible authority to process the above data to determine if I am suitable for therapy with the NEMOS[®] device.

Date

Signature (Patient)

Please send us the recommendation form via e-mail or mail.

Thank you.

tVNS Technologies GmbH

Ebrardstr. 31

91054 Erlangen

E-Mail: support@t-vns.com