PATIENT RX ORDER FORM

To Whom It May Concern:

I am prescribing a pessary for my patient:

____

(Please print patient name)

Please print type of pessary and size below:

____

______________________________________, M.D. Date: ______________________

Please Print Information Below:

Dispensing Clinician/Title: ______________________________________

License No. ____

Facility: ____

Address: ____

City: ____________________________ State: __________ Zip: ____________

Office Phone: ______________________ Fax: __________________________

Patient Name: ____

Address: ____

City: ____________________________ State: __________ Zip: ____________

Phone: ______________________

PLEASE FAX BACK THIS FORM TO: 425-497-1045

PATIENT ORDER FORM FOR EvaCare®PESSARY

Patient Name: ____
(please print)

I hereby authorize use of the following credit card for purchase of a 100% Silicone EvaCare Pessary as prescribed by my physician.

American Express _____ Visa_____ MasterCard _____ Discover________

___ ___ ___ ___--___ ___ ___ ___--___ ___ ___ ___--___ ___ ___ ___

Expiration Date: ________________

Security Code:__________

Purchase Price: $49.95
Plus UPS Shipping of $10
(Sales tax WA)

Please ship to the following address:

_____Patient _____Clinician

Street____

City ____ State _______ Zip ___________

Patient Signature: ____

Patient Phone Number: ____

PLEASE FAX BACK THIS FORM TO
Personal Medical 425-497-1045

Questions: Call 866-839-9260