PRESCRIPTION / ORDER FORM - VitalCough® System

Patient Name: _____
(Required - please print) **First** **Middle** **Last**

Birth Date: _____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

Facility Contact Person: _____
Phone: _____
E-mail: _____
Following Physician/PCP: _____
Phone: _____
E-mail: _____

Patient Contact Name: _____ Relationship to Patient: _____

Phone: _____ ☐ H ☐ C ☐ W Alt Phone: _____ ☐ H ☐ C ☐ W E-mail: _____

Date patient last seen: _____ Is the patient currently in the hospital? ☐ N ☐ Y Discharge Date: _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Clinic Information: Fac#

Phone: Fax:

1. _____
Signature Date (Required - MM/DD/YY)

2. _____
Prescriber's Signature (Required - no stamped signatures accepted)

3. _____
Print Prescriber's First and Last Name (Required)

4. _____
NPI Number (Required)

℞ **Replacement Cough Interface for VitalCough® System**

Number of Refills ____ (Required)

Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records