

PROVENT[®]

sleep apnea therapy

Fax to ioSleep 1-866-751-0789

or scan and email to Rx@ioSleep.com

<input type="checkbox"/>	DR.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	-----	--------------------------	--------------------------	--------------------------

Physician's Written Order

Patient	
Name:	Patient DOB:
Address:	Home Phone #
City: Prov: PC:	Work/Cell #
Email:	
Products	OSA Severity
<input type="checkbox"/> Provent Sleep Apnea Therapy Starter Kit 30-Night Supply (contains 30 pairs)	circle one MILD
<input type="checkbox"/> Refills as required	MODERATE
	SEVERE
Additional Notes: _____	
<input type="checkbox"/> Co-therapy - Positional device - Night Shift™ Sleep Positioner	
<input type="checkbox"/> Other ie. Chin Strap, Pillow _____	

Physician Signature:

stamp accepted

Date:

Phone:

This fax message and any attachments may contain confidential information. If you are not intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing or forwarding.

ioSleep

ioSleep, Inc. - 12-14 Bruce Park Avenue - Toronto, ON M4P 2S3 - ioSleep.com