EvaCare®
Silicone Pessaries

Patient Order Form with R_x for EvaCare Pessary

Patient Name *(Please Print)*: _____

I hereby authorize use of the following Credit Card for purchase of an EvaCare Pessary as prescribed by my physician:

○ AmEx ○ Visa ○ MasterCard ○ Discover

_____
Card Number

Exp: _____ Security Code: _____

Price: **$49.95** plus UPS Shipping **$10***
(Sales tax WA)

Billing Address: _____

_____

_____
City *State* *Zip*

*Payment information must be completed.

Shipping Address: (if different than billing address)

○ Patient Address ○ Physician Office Address

_____
Name

_____
Street

_____
City *State* *Zip*

Patient Phone: _____

Patient Signature:

_____

R_x for EvaCare Pessary

Prescription Required: this section must be completed and signed by Clinician

To whom it may concern: I am prescribing a pessary for my patient listed above.

Pessary type and size: _____

Clinician Signature: _____ Date: _____

Dispensing Clinician/Title: _____ , _____ License #: _____
Please Print

Facility Name: _____

Facility Address: _____

Office Phone: _____ Fax: _____

Please fax this completed form to:
PersonalMed 425-497-1045

For Questions and Information Call 866-839-9260

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