Rx for EvaCare Pessary

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

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

Pessary type and size:_____

Clinician Signature:_____ Date:_____

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

Facility Name:_____

Facility Address:_____

Office Phone:_____ Fax:_____

FOR EMAIL CONFIRMATION:_____

Patient Order Form with Rx for EvaCare Pessary

Patient name *(Please print)*:_____

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

Billing Address:_____

_____

_____
City *State* *Zip*

Shipping Address: (If different than billing address)

◯ Patient Address ◯ Physician Office Address

_____
Name

_____
Street

_____
City *State* *Zip*

*Payment information must be completed:
I hereby authorize use of the following Credit Card for purchase of an EvaCare Pessary as prescribed by my physician:

Patient Phone:_____ Patient Signature:_____

SHRED AFTER USE

◯ AmEx ◯ Visa ◯ Mastercard ◯ Discover

_____
Card Number

Exp:_____Security Code: _____

Please fax this completed form to:
Personal Med 425-497-1045

For Questions and Information Call 866-839-9260

Mailing Address:
Personal Medical Corp
11824 N Creek Pkwy N Ste 101
Bothell WA 98011

personalmed
advancing pelvic health®

SHRED AFTER USE