



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)
No cash or HSA card

Shipping Address: (If different than billing address)

☐ Patient Address ☐ Physician Office Address

Billing Address: _____

City

State

Zip

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: _____

☐ AmEx ☐ Visa ☐ Mastercard ☐ Discover

Card Number

Exp: _____ Security Code: _____

(No Cash or HSA/FSA Cards)

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

For Questions and Information Call 866-839-9260

Rx Patient Order Form 2026-07 V1.0

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


personalmed
advancing pelvic health®

SHRED AFTER USE



SHRED AFTER USE