Respiratory Prescription

Email to info@myreliefpain.com

PATIENT INFORMATION

Name	**Phone**
Date of Birth	**Email**

DIAGNOSIS

- O Obstructive Sleep Apnea (327.23)
- O Central Sleep Apnea (327.27)
- O Mixed Sleep Apnea (780.57)
- O COPD (496)
- O Asthma (493)
- O Other (Please Describe)

Length of Need (99 = Lifetime)

Notes

OXYGEN THERAPY DETAILS (Indicate Multiple Items as Needed)

- O Pulse Dose **(Portable)** Oxygen Therapy
- O Continuous Flow Oxygen Therapy
- O Supplies for the Above as Needed
- O Other (Please Describe)

Settings & Notes

ASTHMA & ALLERGY THERAPY DETAILS (Indicate Multiple Items as Needed)

- O Compressor Nebulizer Machine
- O Valved Holding Chamber
- O Supplies for the Above as Needed
- O Other (Please Describe)

Notes

SUPPLIER INFORMATION

Myreliefpain
14422 Shoreside Way Suite 110 PMB 134
Winter Garden Florida 34787

Toll Free 888-850-2375 **Tax ID** 46-1240847

Email Info@myreliefpain.com

PHYSICIAN INFORMATION

Name	**Address**
License #	**City**
Email	**State / ZIP**
Phone	**Fax**

Signature	**Date**