



PRESCRIPTION / ORDER FORM - VitalCough® System



Patient Name: _____
 (Required - please print) **First** **Middle** **Last**

Birth Date: _____ **Gender:** M F **Primary Language:** _____

Street **City** **State** **Zip**

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

Facility Contact
Person: _____
Phone: _____
E-mail: _____

Following
Physician/PCP: _____
Phone: _____
E-mail: _____

Patient Contact Name: _____ **Relationship to Patient:** _____

Phone: _____ H C W **Alt Phone:** _____ H C W **E-mail:** _____

Date patient last seen: _____ **Is the patient currently in the hospital?** N Y **Discharge Date:** _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
 (The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Clinic Information:	Fac#	
Phone: _____	Fax: _____	
1. _____ Signature Date (Required - MM/DD/YY)		Number of Refills _____ (Required)
2. _____ Prescriber's Signature (Required - no stamped signatures accepted)		
3. _____ Print Prescriber's First and Last Name (Required)		
4. _____ NPI Number (Required)		

Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records