Physician: _____

Phone Number: _____

Address: _____

DEA #: _____ Lic #: _____

Patient Name: _____

Patient Address: _____

Date Prescribed: _____ Patient DOB: _____

Rx

Quantity: 1

ApneaStrip™

Item# 7200B (Drop ship item)

Disposable Sleep Apnea Screener – Adult use Only

❑ Dispense as written

Void after _____

_____

(Signature)