RTech Health Solutions

PRODUCT PRESCRIPTION FORM

PATIENT INFORMATION DATE:________________

Name:____

DOB:____

Address: ____

Phone:____

Email:____

PHYSICIAN INFORMATION

Name:____

Clinic/Hospital:____

Address: ____

Phone:____

Circle one: MD/DO PA NP

License #:____

Physician Signature:

____

Medical Diagnosis/Description:____

Frequency:____

PRODUCTS:

- ☐ iPEP Incentive Positive Expiratory Pressure Therapy Device
- ☐ Pocket PEP Oscillating Positive Expiratory Pressure Therapy Device

iPEP

PocketPEP