

FERTICARE[®] PERSONAL ORDER FORM

PATIENT INFORMATION (Please Print):

Patient Name:

Address:

City / State / Zip Code:

Phone Number:

Date of Birth:

How did you hear about FertiCare[®] Personal?

PHYSICIAN PRESCRIBING INFORMATION (Please Print):

Patient's Primary Diagnosis:

Address:

City / State / Zip Code:

Phone Number:

UPIN Number:

Medical Specialty:

"I PRESCRIBE AND REQUEST A FERTICARE[®] PERSONAL VIBRATOR FOR MY PATIENT NAMED ABOVE BECAUSE FERTICARE[®] PERSONAL VIBRATOR IS MEDICALLY NECESSARY"

Physician's Signature

Date: