Prescription Order Form

Pediarity™ System (including the Gabi device) for Overnight Oximetry Recording

PATIENT INFORMATION			
Patient's name:		**Date of birth:**	**Gender:**
Primary language:	**Email:**	**Phone:**	
Address:			

PHYSICIAN INFORMATION		
Name:	**NPI:**	**Date:**
Email Address:	**Phone:**	

PRESCRIPTION	
Prescription valid for 12 months or other (specify): _____	**Start date:**

MEDICAL JUSTIFICATION FOR PULSE OXIMETER MONITORING	
□ Snoring / choking / pauses in breathing / mouth breathing	□ Nocturnal seizures
□ Headaches	□ Sleepy in school
□ Bedtime struggles	□ Restless sleeper / light sleeper / heavy sleeper
□ Head banging, racking	□ Behavioral or learning problems
□ Insomnia	□ Short attention span
□ Fear of going to sleep / Nightmares	□ Asthma attacks at night
□ Awakening crying, fearful, confused	□ Bedwetting
□ Daytime sleepiness / difficulty awakening in am	□ Grinding teeth
□ Sleep walking / sleep talking	□ Awakening too early
□ Depressed mood	□ Irritable in daytime
□ Enlarged tonsils	□ Problematic peer interactions
□ Recurrent tonsillar infections	□ Sleep paralysis

PRODUCT		
Pediarity™ System (including the Gabi device) for Overnight Oximetry Recording	Qty: 1 (One)	

Signature: