Westfalen

Medische producten en diensten

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Statement of approval

Patient details

Initials: ____________________

Last name: ____________________

Address: ____________________

Postcode/hometown: ____________________

Date of birth: ____________________

Oxygen usage in flow: ____________________

Oxygen usage in hours a day: ____________________

Date: ____________________

Patient Refrence: ____________________

Phone: ____________________

Insurance company: ____________________

Insurance number: ____________________

Other info: ____________________

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Therapy details

	Yes	No
Permitted to fly:	☐	☐
Permitted to travel:	☐	☐
Ambulatory (more then 4 hours a day):	☐	☐
Requires personal assistance:	☐	☐

Comments: ____________________

Signature prescriber:

Name: ____________________

Date: ____________________

Signature patient:

Name: ____________________

Date: ____________________