ALAXO
AIRWAY STENTS

Patient Information/Label

Last Name	First Name
Address	Date of Birth
City	Phone
State	E-Mail

☐ Rx Nasal Airway Stents

Medical
Hx/Notes_____

Referring Physician/Practitioner

Name	E-mail/Phone
Address	Referral Date
City	Practice ID
Zip Code	Signature

Our **Airway Care Team** will be in contact with your patient.

Please **Fax** this form with the requested information to
(623)-526-7297

Email: act@alaxousa.com | Phone: 1-480-431-6763
www.alaxousa.com