Westfalen medical

Zorgt voor lucht in uw leven

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Statement of approval

Patient details

Initials:
Last name:
Address:
Postcode:
Hometown:
Date of birth:
Phone:

Date:
Insurance company:
Insurance number:
Oxygen usage in flow:
Oxygen usage in hours a day:

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: