ALAXO
AIRWAY STENTS

Patient Information/Label

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

☐ Rx Alaxo Nasal Airway Stents

Medical Hx/Notes_____

Referring Physician Information

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

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

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

Email: act@alaxocanada.com | Phone: 1-800-441-3275
www.alaxocanada.com