Patient Information

Patient First Name	Patient Last Name	MI	Phone #	Address	City	State	Zip Code	DOB	Male or Female	Height (in/cm)	Weight (lb/kg)	Allergies	If Applicable: Patient's Authorized Representative	Authorizated Representative Phone #

Prescriber Information															
Prescriber First Name	Prescriber Last Name	Specialty	NPI #	DEA #	Phone #	Fax #	Email	MHLA Clinic ID	Address	City	State	Zip Code	PAP Medication Name	Manufacture	Dose/ Strength

PAP Medication									Clinical Information
Frequency	Quantity	Diagnosis	Date Initiated	Duration of Therapy	Route of Administration	Dispenser Contact Information Phone #	Fax	Email	Additional Relevant Clinical Information