EndeavorRx®

Fax | (877) 503-2391

Please complete all the required fields on this form and submit the form via fax. We will review and reach out if there are any questions or if we need any additional information to process your order.

Patient Name _____ Patient DOB _____

Sex ◯ **Male** ◯ **Female** ◯ *Healthcare provider is aware patient is outside indicated age*

Caregiver Name _____ Caregiver Email _____

Caregiver Cell Phone _____ Home Mailing Address _____

Order Details

Software as a Medical Device Order	**Directions**	**Refills** (Max 12)
EndeavorRx®	**Manufacturer Recommended: Play for 25 minutes a day, 5 days a week for 4 consecutive weeks.**	

ICD-10 (Choose Appropriate) ◯ F90.0 ◯ F90.1 ◯ F90.2 ◯ F90.8 ◯ F90.9 ◯ Other _____

Provider's Name _____ License Type _____ License # _____

License State _____ NPI _____ Fax _____

Office Address _____ Office Phone _____

City _____ State, Zip _____

Person Sending Fax _____

Provider Signature _____ **Date** _____