

Please fill out patient information and email to canadaorder@inhealth.com or fax to (226)-641-5285

Patient information:

First Name _____ Last Name _____

☐ Email _____ ☐ Phone _____

Check box (specify, contact via email or phone)

Hospital Name _____

Date of Birth _____ SLP Name & Phone _____

Address _____

City _____ Providence _____ Postal Code _____

Signature _____ Date _____

Please Choose ONE from the following:

DAY&NIGHT™ HME



BE 1091-10

☐ **NEW** Day&Night™ ClassicFlow® (10 Pack)



BE 1092-10

☐ **NEW** Day&Night™ EasyFlow® (10 Pack)

SPEAKFREE®
HANDS FREE HME



BE 1090EF-6

☐ SpeakFree® ClassicFlow® (6 Pack)



BE 1090EZ-6

☐ SpeakFree® EasyFlow® (6 Pack)

Please Choose TWO from the following:



BE 6082-6

☐ **AccuFit® Round**
(6-pack)



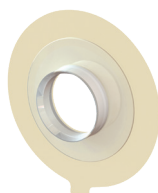
BE 6083-6

☐ **AccuFit® Oval**
(6-pack)



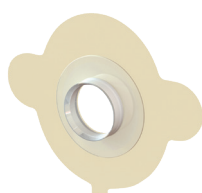
BE 6084-6

☐ **AccuFit® Extra Oval**
(6-pack)



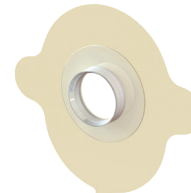
BE 6085-6

☐ **HydroFit® Round**
(6-pack)



BE 6086-6

☐ **HydroFit® Oval**
(6-pack)



BE 6087-6

☐ **HydroFit® Extra Oval**
(6-pack)

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