tidesmedical AURIX

Aurix - System Order Form

Please complete and email to customerservice@tidesmedical.com
This form can also be completed online at www.tidesmedical.com/order-aurix/

Order Date _____

Request Delivery Date _____ Deliver By*: ☐ Early Morning ☐ Mid-morning ☐ Afternoon ☐ 2-day

Company Name/Account # _____

Shipment Ordered by *(print name)* _____

Address _____ City _____ State ___ Zip Code _____

**If no selection is checked, default is Ground delivery service*

Customer Billing Information

Billing Name _____ Attention _____

Address _____ City _____ State _____ Zip Code _____

Purchase Order #: _____ Tax Exempt: ☐ (*Check & attach/send Cert copy*)

Charge Card on File ending in: _____ Signature: _____

Customer Shipping Information

Company/Facility _____

Attention To: _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Email _____

Description	Product #	Order Qty
Aurix® System Combination Kit *(Units of 1, 5 or 10) HOPD only*	**AUSP-01, -05, or AGWR-04**	
Aurix® System 4T *(Single Kit) Physician Office only*	**AUXP-4TR**	
Aurix® MultiFly 4 Pack *(Units of 1 or 25)*	**AUXP-001**	
Aurix® System Centrifuge	**AGSC-04**	
Aurix® XL Expansion Kit *(Units of 1 or 24)*	**AUXP-2T**	
Aurix® Full Expansion Kit *(Units of 1 or 24)*	**AUXP-4T**	

Special Comments/Requirements: