Nebulizer/MDI

PATIENT NAME______________________ SS#____________ DOB ____________ SEX________

ADDRESS______________________ CITY ____________ STATE ________ ZIP________

HOME PHONE______________________ OTHER PHONE______________________

MEDICAID / MEDIPASS / BC/BS / INTEGRAL______________________ POLICY# ______________________

AUTHORIZATION NUMBER ______________________ EXPIRATION DATE? ______________________

PRIMARY CARE PHYSICIAN ______________________ UPIN#/NPI#______________________

ADDRESS ______________________ CITY ____________ STATE ____________ ZIP________

PHONE ______________________ FAX______________________

DIAGNOSIS (ICD-9)__________, __________, __________

PT HAD EQUIPMENT BEFORE? (Y)________, (N) ________ HEIGHT ____________ WEIGHT ____________

EQUIPMENT ORDERED:

(1-QTY) NEBULIZER MACHINE {PURCHASE}(E0570)-MAKE/MODEL ______________ SERIAL # ______________
(1 QTY) NEBULIZER KIT (A7005) MASK KIT, MOUTHPIECE KIT
(1 QTY) MDI - SPACER PLUS MASK (A4627) LOT #______________________

MEDICATION ORDERED:

[ ] XOPENEX 0.63%
[ ] ALBUTEROL .083% (UNIT DOSE ONLY)
[ ] IPRATROPIUM 0.02%
[ ] OTHER______________________

SIG:_____ [ ]QD [ ]BID [ ]TID [ ]QID [ ]Q4H [ ]Q6H [ ]Q8H [ ]PRN [ ]OTHER
OF REFILLS: ____ [ ]PRN [ ]1 [ ]2 [ ]3 [ ]4 [ ]5 [ ]6 [ ]OTHER

PHYSICIAN'S SIGNATURE______________________ DATE ____________

- The undersigned has been trained in the proper use, care, and safety of the equipment.
- The undersigned authorizes the release if any medical information necessary to the development and payment of this claim.
- The undersigned authorizes payment to PM Respiratory Services.
- The undersigned agrees that the home is suitable for the listed equipment.
- The undersigned has received a copy of this form.

PATIENT SIGNATURE ______________________ DATE ____________
PARENT/GUARDIAN/CAREGIVER SIGNATURE______________________
RELATIONSHIP TO PATIENT______________________

White (PM Respiratory Services) *Yellow (Patient)*