



Nebulizer RX

FAX COVER

To: _____ From: _____

Fax: _____ Pages: _____

Phone: _____ Date: _____

Remarks: Urgent For Your Review Please Comment Please Reply

Message: Please complete all the information below for your nebulizer order. This RX (completely filled out) will serve as a detailed order.

Standard Written Order for Nebulizer

Date: _____ Patient Name: _____ DOB: _____

Patient Address: _____

Length of need: 12

Directions/Method of use: _____

Please enter diagnosis code: _____

Frequency of use daily with ordered inhalation treatments.
Quantity per month as listed below for each item:

_____ Nebulizer	Quantity			
_____ Filter	2 per month			Refills: 11
_____ Neb Kits	1 per 6 month	Or	2 per month	Refills: 11
_____ Face Mask	1 per month			Refills: 11

Provider Name (please print): _____

Provider Signature: _____ Date: _____

Provider Address: _____

NPI: _____

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