



1312 Redwood Ave
Grants Pass OR 97527
melody.hannah@todaydme.com

Ph 541-249-9860
Fx 541-249-9859

Nebulizer Detailed Written Order Prior to Delivery

Patient Name: _____ Patient DOB: _____

Order Date: _____



Chart notes Attached (chart notes must include the need for equipment being ordered)

I, the Physician, have seen this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes.

Date of visit prior to order: _____

DIAGNOSIS (Check appropriate diagnosis below) Length of Need: 12 months other

Asthma, Unspecified J45.9

Emphysema, unspecified J43.9

Acute Bronchitis, unspecified J20.9

Pneumonia, unspecified J18.9

COPD, unspecified J44.9

Other _____

Nebulizer Products & accessories are medically necessary (Check equipment/supplies ordered)

Nebulizer with compressor (E0570) Sunset nebulizer compressor NEB100 S/N _____

Disposable Nebulizer Set, 2 Monthly (A7003)

Disposable Filter, 2 monthly (A7013)

Aerosol Mask, 1 Monthly (A7015)

Reusable filter, 1 every 3 months (A7014)

Prescribing Physician's Information

Name & Credentials _____

NPI# _____

Address _____

Telephone _____

Fax _____

Signature _____

Signature Date _____