NORTHEAST MEDICAL PRODUCTS, INC
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Nebulizer Order Form

Patient Demographics:

→ **Date:** ___/___/___
→ **Patient Name:** _____
→ **Patient Address:** _____
→ **Patient Phone Number:** _____
→ **Patient DOB:** ____/____/____ → **Patient Height:** ___'__" → **Patient Weight:** _____ lbs

Please check all that apply:

→ (____)	**a. It is reasonable and necessary to administer albuterol, arformoterol, budesonide, cromolyn, formoterol, ipratropium, levalbuterol or metaproterenol for the management of obstructive pulmonary disease.**
→ (____)	**b. It is reasonable and necessary to administer dornase alpha to a beneficiary with cystic fibrosis.**
→ (____)	**c. It is reasonable and necessary to administer tobramycin to a beneficiary with cystic fibrosis or bronchiectasis.**
→ (____)	**d. It is reasonable and necessary to administer pentamidine to a beneficiary with HIV, pneumocystosis, or complications of organ transplants.**
→ (____)	**e. It is reasonable and necessary to administer acetylcysteine for persistent thick or tenacious pulmonary secretions.**

Nebulizer Compressor Information – Based on the above information, the following items are needed by this patient for the stated length of need:

→ **Item – Description (Please check applicable):**
□ Nebulizer Compressor with Tubing & Mouthpiece (E0570)
□ Adult Nebulizer Mask
□ Pediatric Nebulizer Mask
□ Replacement Tubing and Mouthpiece

→ **ICD-10 Code(s):** _____
→ **Length of Need (Please check one):** (___) Months (___) Lifetime
→ **Face-to-Face Exam Date:**

PLEASE SUPPLY A COPY OF THE CLINICAL NOTES FROM THE FACE-TO-FACE VISIT
(Please be sure and sign, date, and NPI the end of the patient notes)

Prescribing Physician's Name: _____
Prescribing Physician's Address: _____
Physician NPI: _____ **Phone:** _____ **Fax:** _____

Prescribing Physician's Signature: _____
Date