NEBULIZER / PULMONOLOGY

Fax Referral To 718-360-9655 Or Call 718-556-0942

Patient Name _____ SS#_____ DOB _____ Height _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Evening Tel _____ Cell _____ Caregiver Name _____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy
Allergies _____ Current Medications (if necessary, please fax a complete list) _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City_____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

Diagnosis : ☐ J44.9 COPD ☐ J43.9 Emphysema ☐ J44.9 Obstructive chronic bronchitis ☐ J42 Chronic bronchitis ☐ J47.9 Bronchiectasis
☐ J45.909 Asthma, unspecified ☐ Other: _____

Directions for use : _____ BID _____ TID _____ QID _____ Other Length of need / Refills _____ months
(30 day supply provided unless otherwise specified) *(12 months if not otherwise specified)*

Nebulizer: ☐ Pediatric ☐ Adult **Peak Flow Meter:** ☐ Low range 50-390 L/min ☐ Full range 60-810 L/min **Spacers:** ☐ Small (0-18 months) ☐ Medium (1-5 years) ☐ Large (5 years - adult)

PRESCRIPTION

Please attach copies of front and back of Patient's Prescription Insurance Cards and Original Prescription.

PULMOZYME AMPS
☐ 2.5 mg per 2.5 ml vial

TOBI/TOBRAMYCIN
☐ 300 mg per 5 ml vial

Enexia Specialty 252 Port Richmond Ave, Staten Island, NY 10302

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee.
PLEASE NOTE: Nates's Specialty Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.