COACH'S PHARMACY

100 N TEXAS AVENUE, SUITTE A MERCEDES, TX 78570
(956) 514-2420 (956) 514-2530 FAX

PHYSICIAN'S ORDER FOR INHALATION MEDICATION AND EQUIPMENT

PLEASE COMPLETE THE FOLLOWING INFORMATION LEGIBLY: **EFFECTIVE DATE:**_____

PATIENT NAME _____ DATE OF BIRTH: _____

ADDRESS: _____

PATIENT ID NUMBER (PRIMARY): _____

PATIENT ID NUMBER (SECONDARY): _____

ASSIGNED NON ASSIGNED

THIS EQUIPMENT IS: RENTED PURCHASED FOR HOME USE ALREADY PATIENT OWNED

PROGNOSIS POOR FAIR GOOD

DIAGNOSIS: _____

THIS PATIENT NEEDS THE FOLLOWING EQUIPMENT FOR THE STATED TIME PERIOD:

EFFECTIVE DATE	NUMBER OF MONTHS	PROCEDURE CODE	DESCRIPTION
_____	_____	E0570	NEBULIZER WITH COMPRESSOR
_____	_____	A7003	TUBING FOR NEBULIZER
_____	_____	A7015	MASK FOR NEBULIZER

THE PATIENT NEEDS THE FOLLOWING INHALATION DRUGS FOR THE SATED TIME PERIOD:

_____

_____

_____

(TYPE OF SOLUTION AND METHOD OF ADMINISTRATION! MUST BE GIVEN)

I HAVE CONSIDERED THE USE OF A METER DOSE INHALER WITH AND WITHOUT A RESERVOIR OR SPACER AND DECIDED THAT, FOR MEDICAL REASONS, IT WAS NOT SUFFICIENT FOR THE ADMINISTRATION OF NEDDED INHALATION DRUGS.

I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE PRESCRIBED DURABLE MEDICAL EQUIPMENT IS MEDICALLY NECESSARY AS PART OF MY TREATMENT FOR ACCEPTED STANADRDS OF MEDICAL PRACTICE AND TREATMENT OF THIS PATIENT'S CONDITION AND HAS NOT BEEN PRESCRIBED AS "CONVENIENCE EQUIPMENT." . (This order will be good for 12 months after signing)

PHYSICIAN NAME: _____ PHONE NUMBER _____

ADDRESS:

_____

_____ **NPI**

NUMBER_____

PHYSICIAN SIGNATURE _____**DATE**

_____