Continuum
a CHC Solutions Company

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NEBULIZER ORDER FORM

Please attach face sheet w/ patient demographics & insurance info*

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Patient cannot accept deliveries on the following days?
☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat

Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis	**Secondary Diagnosis**
ICD-10 Code: _____	**ICD-10 Code:** _____
*Non-Specified Codes will not qualify for Primary Diagnosis	

PRODUCTS

	QUANTITY
☐ Nebulizer with Compressor	
☐ Adult Reusable Nebulizer Kit (Includes administration set and aerosol mask)	
☐ Adult Disposable Nebulizer Kit (Includes administration set and aerosol mask)	
☐ Pediatric Reusable Nebulizer Kit (Includes administration set and aerosol mask)	
☐ Pediatric Disposable Nebulizer Kit (Includes administration set and aerosol mask)	
☐ Reusable Administration Set	
☐ Disposable Administration Set	
☐ Adult Aerosol Mask	
☐ Pediatric Aerosol Mask	
☐ Other	

Please List Medications below **(or attach with this order)**

Order Date: _____/_____/_____ **Length of Need: _____ months**

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____/_____/_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.