



**\*\*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**

ICD-10 Code: \_\_\_\_\_

\*Non-Specified Codes will not qualify for Primary Diagnosis

**Secondary Diagnosis**

ICD-10 Code: \_\_\_\_\_

**PRODUCTS**

	QUANTITY
<input type="checkbox"/> Nebulizer with Compressor	
<input type="checkbox"/> Adult Reusable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Adult Disposable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Pediatric Reusable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Pediatric Disposable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Reusable Administration Set	
<input type="checkbox"/> Disposable Administration Set	
<input type="checkbox"/> Adult Aerosol Mask	
<input type="checkbox"/> Pediatric Aerosol Mask	
<input type="checkbox"/> 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, 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.

Call **1.888.248.1975** or visit **www.connectchc.com** for additional information.