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PHYSICIANS ORDER FORM

Today's Date: ____ / ____ / ____

PATIENT INFORMATION	DOCTOR INFORMATION
Name _____ First MI Last Address _____ City/State/Zip _____ Phone _____ DOB _____	Name _____ First MI Last Address _____ City/State/Zip _____ Phone _____ Fax _____
PRESCRIPTION INFORMATION	UPIN# _____ DEA# _____
Medication (Please check): Albuterol 0.083 % unit dose Ipratropium Bromide 0.02% - unit dose Xopenex 1.25mg/3ml – unit dose Other: _____ <u>Directions (Please Circle)</u> BID TID QID Q4H Other _____ Number of Refills ____ months ____ years Supplies (Please check box): Nebulizer circuits ____ Kit(s) _____ ____ Mask(s) _____	DIAGNOSIS <input type="checkbox"/> Chronic Obstructive Bronchitis (491.2) <input type="checkbox"/> Emphysema (492.8) <input type="checkbox"/> Chronic Obstructive Asthma (493.2) <input type="checkbox"/> COPD (496) Other _____ Code _____ Other _____ Code _____ Other _____ Code _____
PHYSICIAN'S SIGNATURE:	INSURANCE
PHARMACY USE	PRIMARY Medicare ID: _____ Is Medicare Managed Care? Yes No Medicaid ID: _____ Is Medicaid Managed Care? Yes No SECONDARY Insurance Company _____ Subscriber Name _____ Patient ID# _____ Carrier # _____ Group # _____ Plan# _____