SINUS SCIENCE™ MEDICATED IRRIGATION

900 Calle Plano, Suite M – Camarillo, CA 93012 – Tel 1-866-552-7579 - Fax 1-866-442-7579

1. PATIENT INFORMATION

Patient Name: _____
DOB: _____/_____/_____ Age: _____ M ____ F____
Address: _____
City: _____ ST: ____ Zip: _____
Tel: Home (_____) _____
Work (_____) _____
Cell (_____) _____
Medical Insurance: (or fax copy of card): _____
ID#: _____ Group#: _____
Ins Tel#: (_____) _____
Ins Fax# :(_____) _____

2. EQUIPMENT

☐ **CHECK THIS BOX. Equipment ordered by physician: Grossan Hydro Pulse™. All medications require the Grossan Hydro Pulse™ on the first Rx.**

4. DIAGNOSIS

☐ 473.9 CRS, Unspecified
☐ 477.9 Allergic Rhinitis, Unspecified
☐ 461.9 Acute Sinusitis, Unspecified
☐ 473.0 Chronic Sinusitis, Maxillary
☐ 473.1 CRS, Frontal
☐ 473.2 Chronic Sinusitis, Ethmoidal
☐ 473.3 CRS, Sphenoidal
☐ 461.8 Acute Sinusitis, Pansinusitis
☐ 473.8 CRS, Pansinusitis
☐ 117.90 Mycoses, Unspecified
☐ Other _____

5. MEDICATION ALLERGIES

1._____
2._____
3._____

Culture/Sensitivity/Organism:_____
Comments:_____

3. PRESCRIPTION

Irrigate with 150 ml saline each nostril; add medication vial(s) to the last 200 ml of saline in the medication chamber of the Hydro Pulse™. Irrigate each nostril with 100 ml of medicated saline twice daily for 30 days or as directed.

Unit Dose Medication	Frequency	Days	Refill
☐ Ceftazidime 650 mg	☐ QD ☐ BID ☐ TID	30	
☐ Vancomycin 160 mg	☐ QD ☐ BID ☐ TID	30	
☐ Tobramycin 125 mg	☐ QD ☐ BID ☐ TID	30	
☐ Levofloxacin 100 mg	☐ QD ☐ BID ☐ TID	30	
☐ Mometasone 0.6 mg	☐ QD ☐ BID ☐ TID	30	
☐ Budesonide 0.6 mg	☐ QD ☐ BID ☐ TID	30	
☐ Itraconazole 40 mg	☐ QD ☐ BID ☐ TID	30	
☐ Amphotericin 10 mg	☐ QD ☐ BID ☐ TID	30	
☐ Other _____mg	☐ QD ☐ BID ☐ TID	30	

6. PHYSICIAN VERIFICATION

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Physician:_____
Signature:_____ **Date:**_____ **Contact:**_____
Address:_____
City:_____ **ST:**___ **Zip:**_____
DEA: _____ **St Lic:** _____ **NPI #:** _____
Phone: _____ **Fax:** _____

©2008 Aerosol Science™ Laboratories Inc. ***Fax completed form to ASL PHARMACY™ at 1-866-442-7579***