



1. PATIENT INFORMATION	4. DIAGNOSIS
Patient Name: _____ DOB: ____/____/____ Age: ____ M ____ F Address: _____ City: _____ ST: _____ Zip: _____ Tel: Home (____) _____ Work (____) _____ Cell (____) _____ Email: _____ Medical Insurance: (or fax copy of card): _____ ID#: _____ Group#: _____ Ins Tel#: (____) _____ Ins Fax#: (____) _____	<input type="checkbox"/> 473.9 CRS, Unspecified <input type="checkbox"/> 477.9 Allergic Rhinitis, Unspecified <input type="checkbox"/> 461.9 Acute Sinusitis, Unspecified <input type="checkbox"/> 473.0 Chronic Sinusitis, Maxillary <input type="checkbox"/> 473.1 CRS, Frontal <input type="checkbox"/> 473.2 Chronic Sinusitis, Ethmoidal <input type="checkbox"/> 473.3 CRS, Sphenoidal <input type="checkbox"/> 461.8 Acute Sinusitis, Pansinusitis <input type="checkbox"/> 473.8 CRS, Pansinusitis <input type="checkbox"/> 117.90 Mycoses, Unspecified <input type="checkbox"/> Other _____
2. IRRIGATION	5. MEDICATION ALLERGIES
<input type="checkbox"/> CHECK THIS BOX. Equipment ordered by physician: NeilMed™ Sinus Rinse Bottle. Add medication to 100ml of saline. Irrigate each nostril with 50cc of medicated saline. For irrigation. <input type="checkbox"/> CHECK THIS BOX. Equipment ordered by physician: Grossan Hydro Pulse™. Add medication to the last 200ml of saline. Irrigate each nostril with 100cc of medicated saline. For irrigation.	1. _____ 2. _____ 3. _____ Culture/Sensitivity/Organism: _____ Comments: _____ _____ _____

3. PRESCRIPTION

Unit Dose Medications	Frequency	Days	Refill
<input type="checkbox"/> Ceftazidime (650 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Vancomycin (160 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Tobramycin (125 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Levofloxacin (100 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Mupirocin (15 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Pulmicort® (0.5 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Itraconazole (40 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Amphotericin (10 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Other _____ mg	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	

Combinations Available: BID x 30 Day Dosing

<input type="checkbox"/> Tobramycin (125 mg) + Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Vancomycin (160 mg) + Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Levofloxacin (100 mg) + Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Levofloxacin (100 mg) + Amphotericin B (10 mg) + Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Mupirocin (15 mg) + Tobramycin (125 mg) + Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> TID	30	
<input type="checkbox"/> Tobramycin (125 mg) + Amphotericin B (10mg) + Budesonide (0.6 mg)	<input type="checkbox"/> BID <input type="checkbox"/> 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.

Signature: _____ **Date:** _____ **Contact:** _____
Physician: _____
Address: _____
City: _____ **ST:** _____ **Zip:** _____
State License: _____ **NPI #:** _____
Phone: _____ **Fax:** _____