



Nebulizer Therapy Prescription Form

Patient Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Diagnosis/ICD-9 _____

Check here if MDI are not effective.

What medication is being use: _____
(This info is required by Medicare and Medical Assistance. This is not a prescription for medication.)

Rx: Dispense **Pulmo-aid Nebulizer** and hand-held nebulizer.

Direction for use: _____ Length of need: _____

Physician (Print): _____ License #: _____

Physician Signature _____ Date _____

Erie: 1700 Peach Street, Erie PA 16501
Phone (814) 877-6121 Fax (814) 455-9440

Bradford: 600 Chestnut Street, Bradford PA 16701
Phone (814) 362-8141 Fax (814) 362-9113

Meadville: 303 Chestnut Street, Meadville PA 16335
Phone (814) 337-6900 Fax (814) 337-6902

Jamestown: 512 W. Third, Jamestown NY 14701
Phone (716) 664-5092 Fax (716) 664-6570

Fredonia: 37 W. Main Street, Fredonia NY 14063
Phone (716) 672-4704 Fax (716) 672-4706