

Form provided by:  
Pharmaceutical Specialties, Inc  
150 Cleveland Road Bogart, Georgia 30622  
706-369-9591 / 800-818-6486 Fax: 706-369-9698 / 800-818-6490

**Prescription for e-Flow Nebulizer & Nebulized Medication delivered via eFlow Nebulizer**

Step 1: Please complete Patient Information Section

Step 2: Please order the appropriate Rx and include any specific directions for administration.

**PLEASE FAX TO: 800-818-6490**

**Section 1**

**Patient Information**

Patient Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Patient's Height: \_\_\_\_\_ Patient's Weight: \_\_\_\_\_ Ce; or Alternate Phone: \_\_\_\_\_

\_\_\_\_\_

NO KNOWN DRUG ALLERGIES

YES, PATIENT HAS THE FOLLOWING DRUG ALLERGIES:

**If possible please also fax demographic information sheet with insurance information and a medication profile.**

Rx: eFlow Nebulizer kit Sig: Use as directed with medications below

Rx: \_\_\_\_\_

Refill \_\_\_\_\_ times (up to 1 year)

Date: \_\_\_\_\_

Qty: \_\_\_\_\_

Sig: \_\_\_\_\_

Rx: \_\_\_\_\_

Refill \_\_\_\_\_ times (up to 1 year)

Date: \_\_\_\_\_

Qty: \_\_\_\_\_

Sig: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

DEA: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

License#: \_\_\_\_\_ State: \_\_\_\_\_