Hill's Drug Store, Inc.

705 W. Kirk Pl. San Antonio, Texas 78226

Pharmacy - Ph: (210) 225.7283 Fax: (210) 226.2637

DME - Ph: (210) 226.4300 Fax: (210) 226.4334

Physician's Order Form

Date: _____ DOB: _____

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Phone: _____

CITY: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Social Security: _____

Primary Ins: _____ Policy #: _____ Group #: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Diagnosis: _____

Length of Need: _____ months (99 = lifetime) Prognosis: ☐ Poor ☐ Fair ☐ Good

Physician: _____ Lic #: _____ NPI #: _____

Address: _____ Phone: _____

CITY: _____ State: _____ Zip: _____

Respitory / Nebulizers

Date of Sleep Study: _____ **Patient Owned Nebulizer** ☐ Yes ☐ No

☐ CPAP _____ cm H2O

☐ BiPAP I/E Rate _____ BPM

☐ Humidifier
☐ Heated Humidifier
☐ Full Face Mask
☐ Nasal Mask
☐ Nasal Pillow Mask

☐ Adult Nebulizer
☐ Pediatric Nebulizer

☐ Dome & Mouth Piece
☐ Neb.Kit w/ Tubing
☐ Adult Mask
☐ Pediatric Mask
☐ Aero Chambers Qty: _____

(Inhalation medication needs frequency, strength, medication names)

Patient needs following inhalation medications: _____

_____

_____

I herby give my consent to Hill's Drug Store,Inc. Who shall act as my legal representative/agent in communicating this written prescription, either by fax or personally presented by this patient to the provider of their choice.

_____ _____

Physician's Signature **Date**