

MD Information

FAX TO: 949-551-1950

(This Rx Pad is printed on Request of Physician)

Patient Name: (First) _____		(Last) _____		Sex: _____	
Address: _____		City: _____		State: _____ Zip: _____	
Date of Birth: _____		Home Ph: _____		Cell Ph: _____ Work Ph: _____	
Patient's Height: _____		Patient's Weight: _____		Parent/Guardian if child: _____	
Insurance: _____		ID# _____		Group: _____ PH#: _____	
PLEASE ATTACH CARD COPY!					
Patient Drug Allergies: _____					



PARI SinuStar™
COMPRESSOR NEBULIZER SYSTEM



SinuStar Compressor with SinuStar Nebulizer Cup: dispense 1

***Check each drug request and number of refills for each drug:
Use contents of 1 ampule in SinuStar nebulizer as follows:**

- | | | |
|--|--|---------------|
| <input type="checkbox"/> Tobramycin 100mg/ Clindamycin 200mg | Sig: 100mg/200mg BID x 3 Weeks | Refills _____ |
| <input type="checkbox"/> Amphotericin B 10 mg | Sig: 10mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Betamethasone Na Phosphate 0.8mg | Sig: 0.8mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Cefuroxime 250mg | Sig: 250mg TID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Ciprofloxacin 90mg | Sig: 90mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Fluconazole 10mg | Sig: 10mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Itraconazole 20mg | Sig: 20mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Levofloxacin 75mg | Sig: 75mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Mupirocin 10mg | Sig: 6mg BID x 3 weeks | Refills _____ |
| <input type="checkbox"/> Tobramycin 100 mg | Sig: 100mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Vancomycin 150mg | Sig: 150mg BID X 3 Weeks | Refills _____ |
| <input type="checkbox"/> Other _____ | Dose: _____ Sig: ___ X ___ Weeks _____ | Refills _____ |

DIAGNOSIS: Check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> 473.9 Chronic Sinusitis- Unspecified | <input type="checkbox"/> 473.8 Chronic Sinusitis- Pansinusitis | <input type="checkbox"/> 473.0 Chronic Sinusitis- Maxillary |
| <input type="checkbox"/> 473.1 Chronic Sinusitis- Frontal | <input type="checkbox"/> 473.2 Chronic Sinusitis- Ethmoidal | <input type="checkbox"/> 473.3 Chronic Sinusitis- Sphenoidal |
| <input type="checkbox"/> 461.9 Acute Sinusitis- Unspecified | <input type="checkbox"/> 461.8 Acute Sinusitis- Pansinusitis | <input type="checkbox"/> 477.9 Allergic Rhinitis- Unspecified |
| <input type="checkbox"/> 493.9 Asthma- Unspecified | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Physician's Signature

Date

Physician Name: _____ Address: _____

City: _____ State: _____ Zip: _____

DEA: _____ Phone: _____

License#: _____ State: _____ Fax: _____