

Nebs & Meds
A Division of Sherwood Clinical
Phone: 800-847-3987
Fax: 706-894-2806
www.sherwoodclinical.com

Please place serial # sticker here

Date _____ Referral completed by _____

Patient Name _____ DOB _____ Male ___ Female ___
 Address _____ City _____ State ___ Zip _____
 Responsible Party (parent, legal guardian) _____
 Home _____ Work _____ Cell _____
 Emergency Contact other than patient or guardian _____
 Relationship _____ Phone # _____

Commercial Insurance _____ Medicare _____ Medicaid _____ Peach State _____ AmeriGroup _____ Private Pay _____
*****Please provide enlarged copy of Insurance Card*****
 Primary Member ID / Policy # _____ Group # _____
 Secondary Member ID / Policy # _____ Group # _____
 Commercial Insurance Company _____ # _____
 Policyholder Name _____ DOB _____

Payers require a respiratory or cardiac related diagnosis. General respiratory symptoms such as wheezing or coughing do not qualify.
 Diagnosis _____ ICD9 _____
 Height _____ Weight _____ Allergies _____

Please check appropriate fields **ONLY** if Sherwood Clinical is to dispense medications and/or this is a Medicaid referral.

Drug	Frequency	Qty Dispense	Refills
Albuterol 0.042% ___ 0.083% ___	Tid ___	30 ___	0 ___
Duoneb ___	Qid ___	60 ___	1 ___
Ipratropium Bromide 0.02% ___	Q4hrs Prn ___	90 ___	2 ___
Xopenex 0.31mg ___ 0.63mg ___ 1.25mg ___	Q6hrs Prn ___	120 ___	3 ___
Other _____	Other ___	180 ___ Other ___	4 ___ Other ___

Physician Signature _____ Date _____
 Physician Printed Name _____ Group _____
 Address _____ City _____ State ___ Zip _____
 Phone _____ Fax _____
 License # _____ DEA # _____ NPI # _____

By signing below I am authorizing Sherwood Clinical to release my/my child's medical information to all applicable parties for the purpose of reimbursement.

Responsible Party Signature _____ Date _____