



Request for Product Information / Samples

Fax to: (815) 361-0226

Call Me Make Appointment Send Info Send Samples

* Your Name: _____ Credentials: _____

* Mailing Address: _____

* City: _____ * State: _____ * Zip: _____

* Your Job Title: _____

* Business/Work Telephone Number(s): _____

* Your E-Mail Address(es): _____

* Name of Employer/Hospital/Facility: _____

* RT department head's name & phone number: _____

* Employer's Address (if different than above): _____

* City: _____ * State: _____ * Zip: _____

- | | | |
|--|--|-----|
| 1. Are you responsible for evaluating & selecting aerosol devices for purchase? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. |
| 2. May we send you samples of the Medicator? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. |
| 3. Do you routinely <u>administer</u> aerosol therapy of any type to patients? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. |
| 4. Do you routinely <u>prescribe</u> aerosol therapy of any type for patients? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. |
| 5. Are you concerned about environmental contamination and breathing aerosols? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. |
| 6. Do you administer Xopenex? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. |
| 7. Do you administer inhaled morphine, fentanyl or other opioids? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. |
| 8. Do you administer inhaled antibiotics? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. |
| 9. Do you use concentrated albuterol (0.5%) from multi-dose bottles? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. |
| 10. Do you routinely use any "assess & treat" aerosol delivery protocols? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. |
| 11. Are you concerned about "concurrent therapy" or "treatment stacking"? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. |
| 12. Would you be willing to use a system that saved you time by shortening treatments? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. |
| 13. What brands of aerosol delivery system(s) are you currently using? _____ | | |
| 14. Are you satisfied with their performance? Explain: _____ | | |
| _____ | | |
| 15. What improvements/features would you like to see in an aerosol delivery system? _____ | | |
| _____ | | |
| 16. Do you need any aerosol delivery protocols? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, which? _____ | | |

Thank you!