Respiratory / DME Order

(Office) 775-884-1234 (Fax) 775-884-1241

Patient Information

Name____ DOB___________________ Phone _________________

Address ____ City ________________ State ______ Zip _____________

Patient Diagnoses

_____COPD _____Bronchiectasis _____Hypoxemia _____Diffuse interstitial lung disease

_____Cystic fibrosis _____Pulmonary neoplasm _____Erythrocytosis _____Pulmonary hypertension

_____Obstructive Sleep Apnea _____ Central Sleep Apnea _____ CHF _____ Persistent Asthma

Other__________________________________ Order Date ____________________ Length of Need _____ (Lifetime = 99)

Home Oxygen Equipment

Home Oxygen _______ LPM via nasal canula and Stationary
_____E1390 – Oxygen concentrator, single delivery port
24-hour Portability (choose one)
_____E0431 – Portable gaseous oxygen system, rental
_____E1392 – Portable Oxygen Concentrator, rental

____ Nocturnal Only

____ O2 Mask

____ Conserving Device, titrate to maintain greater or equal to 90% spO2.

O2 Sats Date of test ______
Sp02_____ % @ Rest (88 or lower qualifies)
or
3 Step Test ______ Date of Test
SpO2 _______ % Room Air @ Rest
SpO2 _______ % with Activity
SpO2 _______ % on oxygen ____ LPM

PAP Sleep Therapy Equipment

_____E0601 Continuous Positive Airway Pressure device
_____E0470 Respiratory assist device, bi-level w/o backup
_____E0471– Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface

PAP Device Settings
____
____

_____ E0562 Heated Humidifier ______ Supplies (Mask, Headgear, cushions, tubing, filters, water chamber) ______ LPM O2 Bleed In

Overnight Pulse Oximetry (OPO) Test

Specify environment.

_____ Room Air / _____ On O2 @ __ LPM / _____ On PAP Device

Nebulizer Equipment

_____ E0570 Nebulizer Compressor

_____ A7005, A7003 Nebulizer Supplies

Comments / Other Orders

____

Signed by

Physician's Name (printed) _________________________ Physician's Signature ______________________________________

Date____________________________ NPI__________________________________

** Please include demographics, insurance, qualifying chart notes, & sleep studies**

Thank you for your referral!