Detailed Written Order

Patient Name: _____

Address: _____

DOB: _____ Height: _____ Weight: _____

Diagnosis: _____

Start Date: _____ Length of Need (#in months): _____ 1-99 (99= lifetime)

Oxygen/respiratory equipment

_____ LPM

☐ Oxygen Concentrator Other: _____ ☐ 24 Hour ☐ Nocturnal Other: _____

☐ E0431 Portable Gaseous Oxygen System - Tanks **or** ☐ E1392 Portable Oxygen Concentrator

☐ Conserving device flow setting _____

☐ Oxygen Contents ☐ Gas

Sleep Therapy:

☐ CPAP _____ cmH2O ramp _____

☐ CPAP (Auto-Titrating) Min: _____ cmH2O Max: _____ cmH2O

☐ Bilevel w/o rate IPAP: _____ cmH2O EPAP: _____ cmH2O

☐ Bilevel w/ rate IPAP: _____ cmH2O EPAP: _____ cmH2O rate: _____

Mask Interface: (Choose only 1 mask interface)

☐ Nasal mask (1 per 3 months) ☐ Nasal pillow mask (1 per 3 months) ☐ Full-face mask (1 per 3 months)

Accessories:

☐ Heated humidifier ☐ Nasal pillow cushion (2 per month) ☐ Chinstrap (1 per 6 months)

☐ Cool humidifier ☐ Full-face mask cushion (1 per month) ☐ Filter: Disposable (2 per month)

☐ Humidifier chamber ☐ Tubing (1 per 3 months) ☐ Filter: Non-disposable (1 per 6 months)

☐ Nasal mask cushion (2 per month) ☐ Headgear (1 per 6 months) ☐ Other: _____

Please attach the following (as applicable)

☐ Test results (Oxymetry, ABG, Sleep Study) ☐ Patient demographics sheet

☐ Physician's note (from medicalrecords of patient, documennnting requirement for equipment as well as physician's assessment and expected benefit from the equipment ordered above. Physicians are required to sign and date notes.)

Practitioner name: _____

Address: _____ Phone: _____ NPI: _____

Date of Face-to-face visit prior to ordering this respiratory item: _____ Practitioner signature: _____ Date: _____

fax to: 847-573-1909