PHYSICIAN ORDER – RESPIRATORY THERAPY

Phone: (916) 844-7800 9722 Fair Oaks Blvd, Suite B, Fair Oaks, CA 95630 **FAX: (916) 436-9054**

Patient Name:_____ Date of Birth:_____

Address:_____ Contact Phone:_____

Primary Insurance: _____ Secondary Insurance: _____

DX: COPD(dx:_____) Emphysema(dx:_____) CHF(dx:_____) Asthma(dx:_____)

OSA(dx:_____) Chronic Bronchitis(dx:_____) Other:(dx:_____)_____

Length of Need: 99 **# months (lifetime is 99)** ***DATE OF SERVICE:***_____

Oxygen Therapy

☐ E1390-Stationary Concentrator
☐ E1392-Portable Oxygen Concentrator
☐ K0738 Oxygen Homefilling Device

☐ **Oxygen Flow rate: _____LPM via Nasal Cannula**

☐ **Oxygen Mask Titrate? ☐Yes ☐No**

☐ **Continuous ☐Pulse**

Sleep Therapy

☐ E0601 CPAP Set at_____ cmH2O C-FLEX or EPR Setting: ☐ E0562 Heated Humidifier

☐ E0601 Auto CPAP - Set at:_____ to _____cmH2O(Default Range 4-20 cmH2O) ☐ O2 Bleed-in _____LPM

☐ E0470 Bi-Level - Set at:_____IPAP _____EPAP

☐ E0471 Bi-Level w/ back-up - Set at:_____IPAP _____EPAP _____Back-up Rate

☐ E0471 ☐ ASV or ☐ AVAPS Set at: _____Min. EPAP _____Max. EPAP _____Min. PS. _____Max. PS. _____Tidal Vol.
_____Breath Rate_____ITime _____Rise Time _____Max Pressure ☐ Auto _____AVAPS Rate

☐ MASK: ◯ A7034/A7035-NASAL w/Headgear ◯A7030/A7035--FULL FACE w/Headgear
◯ A7034/A7033/A7035-NASAL PILLOW w/Headgear

Replacement Supplies

☐ A7032 Cushion Replacement Nasal(2 Every 1 month) ☐ A7031 Cushion Replacement Full-Face(Replace Every 1 month)

☐ A7033 Replacement Pillows(Replace 2 Every 1 month) ☐ A7046 Water Chamber for Humidifier(Replace 1 every 6 months)

☐ A7037 Standard Tubing(1 every 3 months) ☐ A4604 Heated Tubing(1 every 3 months)

☐ A7038 Filters - Disposable(2 per month) ☐ A7039 Filters – Non-Disposable(1 every 6 months)

☐ A7035 Headgear(1 every 6 months) ☐ A7036 Chinstrap(1 every 6 month)

Address: _____ City/State_____

NPI#: _____Physician Fax:_____

Physicians Name: _____Physician Signature: _____Date:_____

Clear Submit

v1.0.052018