

# Written Order for Medical Equipment

Patient Name: \_\_\_\_\_ Patient D.O.B: \_\_\_\_\_

Discharge Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Deliver to: ☐ Facility ☐ Home

Length of Need for prescribed Item: \_\_\_\_\_ (99= lifetime)

Prescribe Liter Flow: \_\_\_\_\_ LPM ☐ Continuous ☐ Nocturnal ☐ With Exertion / Ambulation

☐ Nasal Cannula

☐ With PAP Device

☐ Oxygen Concentrator (E1390)

☐ Portable Oxygen Gaseous System (E0431)

☐ Oxygen Contents (E0443)

☐ As necessary perform pulse oximetry at rest and during activities of daily living to evaluate patient for use of a portable oxygen conserving device to be used as directed while maintaining oxygen saturation equal or above 90%.

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician Attestation:** I hereby authorize the use of this document as a legal prescription for the item indicated above. I certify that the above prescription is medically necessary and reasonable for the treatment of this patient.

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Physician NPI #

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date