TEXAS 0^2 TESTING

903-310-3212 903-310-1071 TEXASO2TESTING.COM

PHYSICIAN ORDER

Patient Name: _____ Sex: M ☐ F ☐

Phone #: _____ DOB: _____

Address:_____ City: _____ State: _____ Zip:: _____

PLEASE FAX A COPY OF YOUR INSURANCE CARDS

Medicare/Insurance#:_____ Secondary: _____

Physician: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____ Ph: _____ Fax: _____

Diagnostics ordered by physician:

Pulse Oximetry at rest, while ambulating, 02 recovery if needed, pulmonary assessment and overnight Oximetry (if necessary)

Other: _____

As the referring provider, I certify that I am initiating the above prescribed order for pulmonary testing as a medically necessary part of my overall treatment plan for my patient who is identified above. I also certify that I have discussed potential treatment options with my patient depending on the outcome of the pulmonary testing and diagnosis. I have advised my patient that he/she has a right to choose a durable medical equipment (DME) provider if oxygen therapy is medically indicated after testing and diagnosis. My patient has consented to the referral to the provider listed below as "Oxygen Provider" and to be contacted via telephone by the oxygen provider listed below.

Diagnosis: *(please check all that apply)*

_____ J44.9 COPD _____ J45.998 Asthma _____ R06.02 SOB _____ 150.9 CHF

_____ J96.00 Other Respiratory _____ G47.9 Sleep related _____ Other

Physician Signature: _____

Oxygen Provider: _____

Phone #: _____ Fax #: _____

Email Address: _____