

PATIENT INFORMATION

Patient Name		Phone		Alternate Phone
Address / City / State / Zip		DOB	Gender	Ht /Wt
Primary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Other		Policy / Group #		Phone
Secondary Insurance		Policy /Group #		Phone
<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> OSA <input type="checkbox"/> CHF <input type="checkbox"/> CSA <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Other _____				

OXYGEN THERAPY

LPM ____ Continuous (24 hrs) Nocturnal (8-10 hrs) → Nasal Cannula Other _____ → Portable **Length of Need** ____ **Months (99=Lifetime)**
 Evaluate for Oxygen Conserving Device (Titrate setting via oximetry to maintain SpO² ≥ 90% at rest & w/ ambulation) **Begin Service Date:** _____

Qualifying Test Results: SaO² ____% at Rest Exercise Sleep Testing Facility & Test Date _____
 Results obtained during exercise must show documentation of three tests: At Rest w/o O² ____% & Exercise w/o O² ____% & Exercise with O² ____%

Request Diagnostic Testing by Independent Testing Facility: Third Party Overnight Oximetry Only or Third Party Pulmonary Testing

AEROSOL THERAPY

<input type="checkbox"/> Nebulizer w/Compressor	<input type="checkbox"/> Neb Kits (2 Per Month)	<input type="checkbox"/> Aerosol Mask (1 Per Month)	Length of Need ____ Months (99=Lifetime)
			Begin Service Date: _____
<input type="checkbox"/> Gen DuoNeb (lpr 0.02% 0.5mg/Alb 0.083% 2.5mg/3.0ml)	<input type="checkbox"/> QID (#120) four daily	<input type="checkbox"/> TID (#90) three daily	<input type="checkbox"/> BID (#60) twice daily <input type="checkbox"/> Other
<input type="checkbox"/> Albuterol 0.083% 2.5mg/3.0ml	<input type="checkbox"/> QID (#120) four daily	<input type="checkbox"/> TID (#90) three daily	<input type="checkbox"/> BID (#60) twice daily <input type="checkbox"/> Other
<input type="checkbox"/> Ipratropium 0.02% 0.5mg/2.5ml	<input type="checkbox"/> QID (#120) four daily	<input type="checkbox"/> TID (#90) three daily	<input type="checkbox"/> BID (#60) twice daily <input type="checkbox"/> Other
<input type="checkbox"/> Budesonide 0.25mg/2ml <input type="checkbox"/> Budesonide 0.5mg/2ml	<input type="checkbox"/> BID (#60) twice daily	<input type="checkbox"/> QD (#30) once daily	
<input type="checkbox"/> Brovana 15mcg/2ml	<input type="checkbox"/> BID (#60) twice daily	<input type="checkbox"/> QD (#30) once daily	
<input type="checkbox"/> Perforomist 20mcg/2ml	<input type="checkbox"/> BID (#60) twice daily	<input type="checkbox"/> QD (#30) once daily	
<input type="checkbox"/> Other _____			

Start Date (Medication) _____ Refills: 1 Year 6 3 Other ____ Quantity: 90 Days 30

Order Good for TWELVE MONTHS unless otherwise noted

SLEEP THERAPY

<input type="checkbox"/> CPAP → <input type="checkbox"/> Heated Humidifier → CWP _____	Length of Need ____ Months (99=Lifetime)
<input type="checkbox"/> BiPAP → <input type="checkbox"/> Heated Humidifier → IPAP _____ EPAP _____ Back up Rate (if applicable) _____	Begin Service Date: _____
<input type="checkbox"/> Full Face Mask w/Headgear & Tubing <input type="checkbox"/> Nasal Interface w/Headgear & Tubing	<i>*Please Fax Sleep Study with Order*</i>

(Replacement Frequency: Full Face Mask or Nasal Interface 1 per 3 months, Headgear 1 per 6 months, Nasal Interfaces System or Full Mask System 1 per 3 months, Tubing 1 per 3 months, Cushions or Pillows 2 per month)

DURABLE MEDICAL EQUIPMENT

<input type="checkbox"/> Hosp Bed, Semi-Electric <input type="checkbox"/> Trapeze Bar <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Low Air Loss Mattress <input type="checkbox"/> Suction Pump, Aspirator	Length of Need ____ Months (99=Lifetime)
<input type="checkbox"/> Walker <input type="checkbox"/> Walker w/ Wheels <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Manual Wheelchair w/ Elevating Legrest	Begin Service Date: _____
<input type="checkbox"/> Lift Chair <input type="checkbox"/> Commode <input type="checkbox"/> Other _____	

PHYSICIAN INFORMATION

Physician Name	Phone	Fax
Address / City / State / Zip		NPI
Physician Signature		Date