Fitzsimmons
Home Medical Equipment
A Division of Fitzsimmons Surgical Supply, Inc

RESPIRATORY & DME ORDER FORM

6177 Broadway
Merrillville, IN 46410
Ph (877) 512-7569 | Fax (877) 512-7570

PATIENT INFORMATION

Patient Name		Phone		Alternate Phone
Address / City / State / Zip	DOB	Gender	Ht /Wt	SS#
Primary Insurance ☐ Medicare ☐ Other		Policy / Group #		Phone
Secondary Insurance		Policy /Group #		Phone

☐ **Asthma** ☐ **COPD** ☐ **OSA** ☐ **CHF** ☐ **CSA** ☐ **Emphysema** ☐ **Chronic Bronchitis** ☐ **Bronchiectasis** ☐ **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 $SpO^2 \geq 90\%$ at rest & w/ ambulation) **Begin Service Date:** ___________________

Qualifying Test Results: $Sa0^2$ _______% at ☐ Rest ☐ Exercise ☐ Sleep Testing Facility & Test Date ____
Results obtained during exercise must show documentation of three tests: At Rest w/o O^2 ______% & Exercise w/o O^2 ______% & Exercise with O^2 ______%

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

AEROSOL THERAPY

☐ Nebulizer w/Compressor ☐ Neb Kits (2 Per Month) ☐ Aerosol Mask (1 Per Month) **Length of Need_____ Months (99=Lifetime)**
Begin Service Date: ___________________

☐ Gen DuoNeb (Ipr 0.02% 0.5mg/Alb 0.083% 2.5mg/3.0ml) ☐ QID (#120) four daily ☐ TID (#90) three daily ☐ BID (#60) twice daily ☐ Other
☐ Albuterol 0.083% 2.5mg/3.0ml ☐ QID (#120) four daily ☐ TID (#90) three daily ☐ BID (#60) twice daily ☐ Other
☐ Ipratropium 0.02% 0.5mg/2.5ml ☐ QID (#120) four daily ☐ TID (#90) three daily ☐ BID (#60) twice daily ☐ Other
☐ Budesonide 0.25mg/2ml ☐ Budesonide 0.5mg/2ml ☐ BID (#60) twice daily ☐ QD (#30) once daily
☐ Brovana 15mcg/2ml ☐ BID (#60) twice daily ☐ QD (#30) once daily
☐ Perforomist 20mcg/2ml ☐ BID (#60) twice daily ☐ QD (#30) once daily
☐ Other ____________________________ ____

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

Order Good for TWELVE MONTHS unless otherwise noted

SLEEP THERAPY

☐ CPAP → ☐ Heated Humidifier → CWP _______ **Length of Need_____ Months (99=Lifetime)**
☐ BiPAP → ☐ Heated Humidifier → IPAP _______ EPAP ________ Back up Rate (if applicable) _______ **Begin Service Date:** ___________________
☐ Full Face Mask w/Headgear & Tubing ☐ Nasal Interface w/Headgear & Tubing **Please Fax Sleep Study with Order**
(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

☐ Hosp Bed, Semi-Electric ☐ Trapeze Bar ☐ Hoyer Lift ☐ Low Air Loss Mattress ☐ Suction Pump, Aspirator **Length of Need_____ Months (99=Lifetime)**
☐ Walker ☐ Walker w/ Wheels ☐ Manual Wheelchair ☐ Manual Wheelchair w/ Elevating Legrest **Begin Service Date:** ___________________
☐ Lift Chair ☐ Commode ☐ Other___________________

PHYSICIAN INFORMATION

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

Accredited by The Joint Commission on Accreditation of Healthcare Organizations

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