

## RESPIRATORY SERVICES PRESCRIPTION

<b>Patient Name:</b>	<b>Phone #:</b>	<b>Date:</b>
<b>Address:</b>		<b>DOB:</b>
<b>City:</b>	<b>State:</b>	<b>Zip:</b>

## DIAGNOSIS

<input type="checkbox"/> COPD (J44.9)	<input type="checkbox"/> Chronic Bronchitis (J41.1)	<input type="checkbox"/> Hypoxemia (R09.02)	<input type="checkbox"/> Emphysema (J43.9)
<input type="checkbox"/> CHF (I50.9)	<input type="checkbox"/> Central Sleep Apnea (G47.31)	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> OSA (G47.33)	<input type="checkbox"/> Asthma (J45.909)	<b>Length of Need:</b> <input type="checkbox"/> Lifetime <input type="checkbox"/> Months _____	

## OXYGEN TESTING ORDER

<input type="checkbox"/> Overnight Oximetry on Room Air	<input type="checkbox"/> on O2	<input type="checkbox"/> on PAP	<input type="checkbox"/> Capnography with Oximetry
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## OXYGEN EQUIPMENT PRESCRIPTION

Home Oxygen _____ lpm	Stationary Concentrator & Humidification	Choose Only One
Administered	Route of Delivery	<input type="checkbox"/> Portable Tank
<input type="checkbox"/> Nocturnal <input type="checkbox"/> 24 Hours	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> O2 Mask	<input type="checkbox"/> Transfilling Device
		<input type="checkbox"/> Portable Concentrator

## SLEEP THERAPY PRESCRIPTION

<input type="checkbox"/> CPAP _____ cm/H <sub>2</sub> O	<input type="checkbox"/> Auto Mode _____ - _____	*Please include a copy of patients sleep study results with this request.		
<input type="checkbox"/> BIPAP	<input type="checkbox"/> Auto Mode _____ - _____	IPAP _____ cm/H <sub>2</sub> O	EPAP _____ cm/H <sub>2</sub> O	Min PS _____ cm/H <sub>2</sub> O Max PS _____ cm/H <sub>2</sub> O
<input type="checkbox"/> BIPAP ST	IPAP _____ cm/H <sub>2</sub> O	EPAP _____ cm/H <sub>2</sub> O	Breath Rate _____ BPM, I Time(Ti) _____	Rise Time _____
<input type="checkbox"/> BIPAP ASV	Max Pressure _____ cm/H <sub>2</sub> O	EPAP _____ cm/H <sub>2</sub> O	Max PS _____ cm/H <sub>2</sub> O	Min PS _____ cm/H <sub>2</sub> O Breath Rate _____ BPM
<input type="checkbox"/> Heated Humidifier	<input type="checkbox"/> Disposable Filter	<input type="checkbox"/> Reusable Filter		
<input type="checkbox"/> Patient to choose mask to comfort, OR <input type="checkbox"/> Mask Type _____ <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L _____ LPM Oxygen Bled.In				

## NEBULIZER PRESCRIPTION

<input type="checkbox"/> Nebulizer Compressor	<input type="checkbox"/> Walking Aids <input type="checkbox"/> Front Wheeled Walker <input type="checkbox"/> Walker with Seat
<input type="checkbox"/> Nebulizer Reusable Supply Kit	<input type="checkbox"/> Hospital Bed-Semi-Electric
<input type="checkbox"/> Nebulizer Medication to be forwarded to pharmacy	<input type="checkbox"/> Wheelchair* <input type="checkbox"/> Standard
	<input type="checkbox"/> ELR's

## MEDICAL EQUIPMENT

**\*Required Information**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**\*PLEASE INCLUDE ANY SUPPORTING DOCUMENTATION**

<b>Physician's Name:</b>	<b>NPI#</b>
<b>Physician's Signature:</b>	<b>Date:</b>

**Please Fax: This Prescription • Patients Demographics • Patients Insurance • Qualifying Chart Notes**

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