Owens

YUBA CITY
T: 530-924-2768
T: 844-890-2768
F: 530-387-2013

RESPIRATORY SERVICES PRESCRIPTION

Patient Name:	Phone #:	Date:
Address:		DOB:
City:	State:	Zip:

DIAGNOSIS

☐ COPD (J44.9) ☐ Chronic Bronchitis (J41.1) ☐ Hypoxemia (R09.02) ☐ Emphysema (J43.9)

☐ CHF (I50.9) ☐ Central Sleep Apnea (G47.31) ☐ Other: _____

☐ OSA (G47.33) ☐ Asthma (J45.909) **Length of Need:** ☐ Lifetime ☐ Months _____

OXYGEN TESTING ORDER

☐ **Overnight Oximetry on Room Air** ☐ **on O2** ☐ **on PAP** ☐ **Capnography with Oximetry**

OXYGEN EQUIPMENT PRESCRIPTION

Home Oxygen_____ lpm

Administered
☐ Nocturnal ☐ 24 Hours

Stationary Concentrator & Humidification

Route of Delivery
☐ Nasal Cannula ☐ O2 Mask

Choose Only One
☐ Portable Tank
☐ Transfilling Device
☐ Portable Concentrator

SLEEP THERAPY PRESCRIPTION

☐ **CPAP** _____cm/H_20 ☐ Auto Mode____-____ *Please include a copy of patients sleep study results with this request.

☐ **BIPAP** ☐ Auto Mode____-____ **IPAP**____cm/H_20 **EPAP**____cm/H_20 Min **PS**____cm/H_20 Max **PS**____cm/H_20

☐ **BIPAP ST** **IPAP**____cm/H_20 **EPAP**____cm/H_20 **Breath Rate**____BPM, I Time(Ti) _____ Rise Time_____

☐ **BIPAP ASV** **Max Pressure**____cm/H_20 **EPAP**____cm/H_20 **Max PS**____cm/H_20 **Min PS**____cm/H_20 **Breath Rate**____BPM

☐ Heated Humidifier ☐ Disposable Filter ☐ Reusable Filter

☐ Patient to choose mask to comfort, OR ☐ Mask Type_____ ☐ S ☐ M ☐ L _____LPM Oxygen Bled.In

NEBULIZER PRESCRIPTION

☐ **Nebulizer Compressor**

☐ **Nebulizer Reusable Supply Kit**

☐ **Nebulizer Medication** to be forwarded to pharmacy

MEDICAL EQUIPMENT

☐ **Walking Aids** ☐ Front Wheeled Walker ☐ Walker with Seat

☐ **Hospital Bed-Semi-Electric**

☐ **Wheelchair*** ☐ Standard

☐ **ELR's**

***Required Information**
Height: _____
Weight: _____

***PLEASE INCLUDE ANY SUPPORTING DOCUMENTATION**

Physician's Name:	NPI#
Physician's Signature:	Date:

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