

RESPIRATORY SERVICES PRESCRIPTION

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

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)	Length of Need: <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 ₂ 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 ₂ O	EPAP _____ cm/H ₂ O	Min PS _____ cm/H ₂ O Max PS _____ cm/H ₂ O
<input type="checkbox"/> BIPAP ST	IPAP _____ cm/H ₂ O	EPAP _____ cm/H ₂ O	Breath Rate _____ BPM, I Time(Ti) _____	Rise Time _____
<input type="checkbox"/> BIPAP ASV	Max Pressure _____ cm/H ₂ O	EPAP _____ cm/H ₂ O	Max PS _____ cm/H ₂ O	Min PS _____ cm/H ₂ 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

MEDICAL EQUIPMENT

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

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