



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"/> COPD w/Asthma (J44.0)	<input type="checkbox"/> CHF (I50.9)	<input type="checkbox"/> Central Sleep Apnea (G47.31)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> COPD w/Bronchitis (J44.1)	<input type="checkbox"/> OSA (G47.33)	<input type="checkbox"/> Persistent Asthma (J45.40)	Length of Need: <input type="checkbox"/> Lifetime <input type="checkbox"/> Months _____

OXYGEN

<input type="checkbox"/> Overnight Oximetry Test (Room Air)	<input type="checkbox"/> Capnography	<input type="checkbox"/> On O2	<input type="checkbox"/> On CPAP/BIPAP
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OXYGEN EQUIPMENT PRESCRIPTION

Home Oxygen _____ lpm/via nasal cannula & humidification prn/concentrator <input type="checkbox"/> O2 Mask Sats: _____ <input type="checkbox"/> Nocturnal O2 Only	<input type="checkbox"/> 24 Hours (with portable) <input type="checkbox"/> Transfilling Device <input type="checkbox"/> Conserving Device* <input type="checkbox"/> Portable Concentrator <small>*RT to assess patient's need for conserving device. Titrate liter flow to keep SaO₂ greater or equal to 90%.</small>
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SLEEP THERAPY PRESCRIPTION

<input type="checkbox"/> CPAP (E0601) _____ cm/H ₂ O	<input type="checkbox"/> Auto Mode _____ - _____	<small>*Please include a copy of patients sleep study results with this request.</small>
<input type="checkbox"/> BIPAP (E0470) <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 (E0471)	IPAP _____ cm/H ₂ O EPAP _____ cm/H ₂ O	Breath Rate _____ BPM, I Time(Ti) _____ Rise Time _____
<input type="checkbox"/> BIPAP ASV (E0471)	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 (E0562)	<input type="checkbox"/> Supplies (Mask, headgear, tubing, filter, cushions)	_____ LPM Oxygen Bled.In

NEBULIZER PRESCRIPTION

MEDICAL EQUIPMENT

<input type="checkbox"/> Nebulizer Compressor (E0570)	<input type="checkbox"/> Walking Aids <input type="checkbox"/> Front Wheeled Walker <input type="checkbox"/> Walker with Seat
<input type="checkbox"/> Nebulizer Supplies (A7005, A7003)	<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
	Required Information Height: _____ Weight: _____

***PLEASE INCLUDE ANY SUPPORTING DOCUMENTATION**

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

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

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