

Patient Order Fax Form

fax 440-232-3411
phone 1-800-824-1400

Patient Name: _____ Start Date: _____
 Insurance Name: _____ Policy # _____
 Address: _____ Phone: _____
 City/Zip: _____ Date of Birth: _____

O₂ Liter Flow _____ Hours of Usage _____ Mask/Cannula _____ Humidity _____ pO₂ or Sat _____ (Room Air)

Date/Place of Test _____

CPAP cmH₂O _____ Ramp _____ Mask _____ Humidity _____ Cool Heated
 BiPAP S ST IPAP _____ EPAP _____ R.R. _____ Ramp _____
 Aerosol Machine E0570 Frequency _____ Quantity: 1 Month Supply
 Medications Albuterol 0.083% 3ml Other
 Ipratropium .2% 2.5ml Refills: _____
 Other _____

Hospital Bed & Rails Wheelchair w/footrests Wheelchair w/legrests Ht. _____ Wt. _____
 Enteral (please specify) _____
 Other HME _____

Respiratory Assessment Overnight Oximetry ___ on Rm. Air ___ on O₂ @ ___ LPM

PULSE OXIMETRY ORDERS: Oxygen Conserver may be used if SpO₂ ≥ 90%.
 Prior to D/C of home O₂ - rest, activity, nocturnal.
 To titrate flow on conserver - keep SpO₂ > 90%.

Physician Name: _____ Phone: _____
 Address: _____
 Signature: _____ Signature Date: _____
 UPIN: _____

DIAGNOSIS: _____ **Length of Need:** _____
 COPD (496)
 Emphysema (492)
 Chronic Obstructive Bronchitis (491.2)
 Chronic Obstructive Asthma (493.2)
 Bronchiectasis (494)
 Asthma (493)
 Abnormal Sputum (786.4)
 Other _____
 Permanent or Temp Condition
 Patient Allergies _____

**PLEASE FAX YOUR PATIENT'S
 INSURANCE INFORMATION
 ALONG WITH THIS FORM.
 THANK YOU.**

(Please indicate if you would like a phone call verifying receipt of this fax. yes no)