Medical Service Company

Oxygen Order Form

Sales Rep Name: _____
Phone #: _____
Fax #: _____

PATIENT INFORMATION

Patient Name: _____ **Date Prescribed:** ____/____/____

Date of Birth: ____/____/____ **Length of Need: 99 months (lifetime) OR** ___ **# of months)**

Home Phone/Cell #: _____ **ICD-10 (Diagnosis):** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

OXYGEN EQUIPMENT (check all applicable boxes)

☐ **Oxygen Concentrator** Liter Flow: _____ LPM

Method of Delivery: **Frequency:**

☐ Nasal Cannula ☐ Mask ☐ Bleed into PAP ☐ Other _____ ☐ Continuous ☐ Activity ☐ Nocturnal

☐ **Portable Oxygen Concentrator** (POC) Pulse Setting (1-5): _____
POC pulse settings do not correlate to LPM settings

☐ **Evaluate for POC/Conserving Device**

☐ Maintain O2 Sat >: _____ %

Per MSC protocol: *If minimum is not indicated, O2 Saturation will be maintained at a minimum of 90%*

OR

☐ **Portable Oxygen Gas Tanks**

Method of Delivery:

☐ Nasal Cannula ☐ Mask

☐ Other _____

☐ **Pulse Oximetry Services** Overnight Oximetry on: ☐ Room Air ☐ Oxygen _____ LPM ☐ PAP Device

TESTING

I have reviewed the qualifying oxygen testing that was completed on:

____/____/____

(Enter date of test)

Please provide the following records with each oxygen referral:

☐ The most recent qualifying test results, **signed and dated** by the physician,

OR

☐ Medical records indicating the physician reviewed and evaluated the test results, **signed and dated** by the physician,

AND

☐ Recent documentation to support the need for Oxygen, **signed and dated** by the physician

Physician's Signature: _____ **Date:** ____/____/____

Physician's Printed Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____