Oxygen & Respiratory Referral Form

Phone: (909) 657-5557
To place an order, please complete and FAX to: (909) 657-9990

Patient Name: ______________________________**Date of Birth:** _____________**RX Date:**___________

Diagnosis: ☐COPD (J44.9) ☐Extrinsic Asthma (J45.20) ☐Chronic Bronchitis (J42)

☐Acute Bronchiolitis (J20.9) ☐Chronic Obstructive Asthma (J44.9) ☐Emphysema (J43.9)

☐CHF (I50.9) ☐Other: _________________ __________________ _______________

Length of Need: __________________ (If lifetime, use 99)

☐**Oxygen** LPM _______ via ☐Nasal Cannula ☐Mask

Please Specify Usage: ☐Continuous ☐ Nocturnal ☐Exercise

Please Specify Modality: ☐Concentrator ☐Portable ☐Other _____________________

☐**Conserving Device**
(***Note to ordering physician**: before prescribing, please be aware that a conserving device is NOT intended for use during sleep or by patients who breathe greater than 40 breaths/minute or who fail to consistently trigger the device due to a weak inspiratory effort.)*

Test Results: Pulse Oximetry/SaO2 ________________ ABG/PaO2: _____________

Date Tested: ___________ Where Tested: ______ Test Condition: ☐Nocturnal ☐Rest ☐Exercise

☐**Nebulizer Compressor** Non-Disposable Neb Kit (A7005 1 per 6 months)

☐**Respiratory Services** Overnight Oximetry to be performed on:

☐Room Air ☐Oxygen at___ LPM ☐CPAP/BiPAP/APAP ☐CPAP/BiPAP w/ Oxygen at ____ LPM
Comments/Other Orders:

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Please provide face-to-face chart notes and test results that support medical necessity with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: ____________________________**NPI:**_____________________**FAX:**____________

Physician's Signature: _______________________________ **Signature Date:** ____________________________