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PHYSICIAN'S ORDER FORM

Patient's Name: _____ M / F DOB _____
Phone _____ Email _____
Address _____ City _____ State _____Zip _____
Primary Insurance _____ Secondary Insurance _____
(Medicare patients provide patient Medicare Number) _____
Diagnosis _____

EQUIPMENT PRESCRIBED

NON-INVASIVE PRESSURE SUPPORT VENTILATION, E0464

❑ Chronic Respiratory Failure (596.10) ❑ COPD (544.9) ❑ Other_____

Modes: ❑AVAPS AE
Settings (Suggested): PS Min: _____ EPAP Min: _____
PS Max: _____ EPAP Max: _____
MAX PRESSURE: _____
Inspiratory Time: _____ ❑ (.8 – 1.5)
Rate: _____ ❑ AUTO (Preferred)
Tidal Volume: _____ or ❑ (6-8cc/kg IBW)
Mask Interface: ❑ Fit For Comfort ❑ MPV
Hours of Use: ❑ Day ❑ During Sleep
Length of Need: ❑ Lifetime – 99 Months ❑ Other _____
Supplemental Oxygen: ❑ Titrate o2 to maintain SaO2> _____ ❑ FiO2/lpm,
PLEASE PROVIDE CLINICAL EVIDENCE TO SUPPORT DIAGNOSIS

OXYGEN CONCENTRATOR

Method of Administration:
□ Cannula □ Mask -Flow rate: _____ LPM Usage: □ Continuous □ While sleeping _____# of hours per day

- ❑ PORTABLE OXYGEN: Is the patient mobile within the home. □ YES □ NO
- ❑ Evaluation for use of conserving device/portable oxygen concentrator
- ❑ Titrate setting to maintain SPO2 of 90% or higher with exercise
- ❑ Initial assessment by respiratory therapist
- ❑ OTHER: _____

PLEASE PROVIDE PATIENT'S OXYGEN TESTING QUALIFICATIONS WITH ORDER FORM

PHYSICIAN INFORMATION

Date: _____ Physician's Signature: _____
UPIN: _____ Physician's Name: _____
Phone: _____ Address: _____
DEA: _____ State ID: _____ City/ST/Zip: _____