RT Medical - Jenny: 615-469-7299 ext 114 RT Medical Fax: 615-469-7596

PATIENT INFORMATION

Patient: _____ Patient Contact: _____

DOB: _____ Patient Height/Weight _____

Order Date: _____

DIAGNOSIS

__COPD __CHF __OSA ___Pulmonary Fibrosis ___Asthma ___Interstitial Lung Disease ___Emphysema ___Chronic Bronchitis

__ Other: _____ Length of Need: _____(99=lifetime)

DIAGNOSTIC TESTING

__Overnight Oximetry on: __RA, __O2, __on PAP

__Daytime Pulse Oximetry

__Titrate Patient for Conserving Device

RESPIRATORY EQUIPMENT - OXYGEN & NEBULIZER

__Oxygen: _____LPM – Continuous__ Nocturnal __

__Nasal Cannula __Bleed into PAP __via Trach__%

__Portability _____LPM via nasal cannula

__w/ conserving device via nasal cannula _____LPM

__Nebulizer

__Neb Kit (non-disposable 1 per 6 mos)

__Large Volume Compressor for Trach Collar

PAP AND SUPPLIES

__CPAP – Pressure _____

__Auto CPAP – Range ___ to ___

__BiLevel – Pressure _____

__BiLevel ST – Pressure_____, Back-up Rate____

__Auto BiLevel – Pressure _____

__Heated Humidifier __Standard Tubing __Mask Fitting __Water Chamber __Chinstrap

OTHER EQUIPMENT

__Bedside Commode __Hospital Bed __APP __Walker __Other: _____

SPECIAL INSTRUCTIONS

_____

_____

ADDITIONAL DOCUMENTATION NEEDED

IF YOU HAVE NOT ALREADY PROVIDED, PLEASE SEND ALL DOCUMENTS REQUIRED FOR ALL EQUIPMENT ORDERS, COPIES OF VISIT NOTES DOCUMENTING NEED. THESE NOTES MUST INCLUDE PATIENT COMPLAINT, ASSESSMENT, TEST RESULTS, TREATMENT PLAN, AND PREVIOUS TREATMENTS TRIED FOR EACH SPECIFIC PIECE OF EQUIPMENT TO HELP ASSURE PAYMENT BY INSURANCE.

PHYSICIAN INFORMATION

Practitioner's Name: _____ NPI # _____

Physician Signature: _____ Date _____