BayShore Dura Medical
PALM BEACH ♦ BROWARD ♦ DADE ♦ MONROE

Detailed Written Order

Patient Name: _____ **D.O.B** _____

Date of Service: _____ **Diagnosis:** _____

_____

_____

_____

Initial date:_____ **Renewal date:**_____ **Date Last Seen Patient:** _____

Physician's Name: _____ **NPI#:** _____ **Telephone:**_____

Physician's Address:_____ **Fax:**_____

_____

Physician's Order: May use conserving device if receiving oxygen therapy

Testing Lab & Location : _____

Oxygen @ ____ LPM or ____ %Fi02 ____ continuous: ____ ambulation: ____ sleep: **via** ____ nasal cannulae: ____ mask: ____ trach collar: Date of Oxygen Test: _____; Sp02 _____% : PO2 _____MmHg

DME ordered :

_____

_____

_____

_____

_____

_____

I hereby attest that the medical record entry reflects signatures/notations that I made in my capacity as the attending physician when I treated the above listed Medicare or other beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Length of Need: ( ) Month (s) or ( ) Lifetime

_____

Physician's Signature :
(must be signed by a MD or DO)

_____

Date:

Once signed by the physician please fax back to (305) 821-1297 / (786) 999-6695. Thank you.

7835 N.W. 148th Street, Miami Lakes, Florida 33016 / 1470 N. Congress Ave, Suite#103, West Palm Beach, FL. 33409
Telephone: (800) 331-0530; Fax: (888) 316-9151