**PHYSICIAN ORDER**

**For Durable Medical Equipment**

# PATIENT INFORMATION

Name: DOB:

Date:

Address: City:

State:

Zip:

Phone:

Estimated LON:99 Months (lifetime) OR Date of Face-to-Face Needs Assessment:

# DIAGNOSIS

Ht: Wt: Drug Allergies:

ALS 335.20 Chronic Bronchitis 491.20 Hypoxemia 799.02 Respiratory Failure 518.81

Asthma, Extrinsic 493.00 COPD 496 Lung Cancer 162.9 Resp Insufficiency 786.09

Asthma, 493.

CVA 434.91 OSA 327.23 Other:

Central Sleep Apnea 327.21 Emphysema 492.8 Pneumonia 486

CHF 428.0 Hypoventilation Syn 327.25 Pulmonary Fibrosis 515

# RESPIRATORY EQUIPMENT

Oxygen Concentrator OR Other:

LPM: Hrs/Day: Via: Nasal Cannula OR Mask

Oxygen Portable System Conserving Device Nocturnal use only, Bleed in PAP Nebulizer Compressor w/Reusable admin set OR Mask OR Other:

Medication & Dosage:

QID BID OR Other: 12 Month Length of Need OR

*\*Medications Provided by PulmoDose Dispense as one month supply*

# SLEEP THERAPY

CPAP

 cmH2 O Ramp:

CPAP (Auto-Titrating) Min: cmH2 O Max: cmH2 O

BiPAP IPAP: cmH2 O EPAP: cmH2 O Optional:

RAD w/Backup IPAP: cmH2 O EPAP: cmH2 O Rate: (Rise Time Max Insp Time Insp Time %)

*Mask Interface* ***(choose only 1 mask interface):***

Nasal Mask (1 per 3 months) Nasal Pillow Mask (1 per 3 months) Full Face Mask (1 per 3 months)

*Accessories:*

|  |  |  |
| --- | --- | --- |
| Heated Humidifier | Nasal Pillow Cushion (2 pair per month) | Chinstrap (1 per 6 months) |
| Humidifier (Passover) | Full Face Mask Cushion (1 per month) | Filter: Disposable (2 per month) |
| Humidifier Chamber (1 per 6 months) | Tubing (1 per 3 months) | Filter: Non-disposable (1 per 6 months) |
| Nasal Mask Cushion (2 per month) | Headgear (1 per 6 months) | Other:  |

# DIAGNOSTIC

Overnight Oximetry on Room Air OR Other: \_ Other: Sleep Screening w/AHI

# WHEELCHAIR & ACCESSORIES

|  |  |  |
| --- | --- | --- |
| Standard (K-1) | Pressure Reducing Cushion | Wheel Lock Extensions |
| Lightweight (K-3) | Elevating Leg Rests | Safety Belt |
| High-Strength Lightweight (K-4) | Anti-tippers | Other:  |
| Heavy Duty (K-6) |  |  |

**HOSPITAL BED & ACCESSORIES**

Semi-Electric OR Other: \_ Patient Lift

Trapeze Pressure Reducing Mattress Specific Type:

# AMBULATORY AIDS

|  |  |  |
| --- | --- | --- |
| Walker (Folding) | Walker (Heavy Duty w/Brakes) | Crutches |
| Walker (Folding w/ Wheels) | Walker (Heavy Duty) | Cane |
| Walker (Rollator) | Bedside Commode | Quad Cane |

**OTHER**

Specify:

**PLEASE ATTACH THE FOLLOWING (AS APPLICABLE)**

Test Results (oximetry, ABG, Sleep Study) Patient Demographics Sheet

Copy of Patient’s Insurance Card

Physician’s Notes *(from patient’s medical record documenting face-to-face equipment needs assessment and expected benefit from equipment ordered above. Physician must sign and date notes. In accordance with Medicare, a NP, CNS or PA may perform evaluation however, physician must co-sign and date)*

# PHYSICIAN INFORMATION

Name:

NPI: \_ Phone:

Fax:

Address: City: \_ State: \_ Zip:

**Physician Signature:**

**Date:**