**RESPIRATORY SERVICES**
T: 530-924-2768
T: 844-890-2768
F: 530-387-2013

# RESPIRATORY SERVICES PRESCRIPTION

| Patient Name: | Phone #: | Date: |
|---|---|---|
| Address: | | DOB: |
| City: | State: | Zip: |

## DIAGNOSIS

☐ COPD (J44.9) ☐ Chronic Bronchitis (J41.1) ☐ Hypoxemia (R09.02) ☐ Emphysema (J43.9)

☐ COPD w/Asthma (J44.0) ☐ CHF (I50.9) ☐ Central Sleep Apea (G47.31) ☐ Other: _____

☐ COPD w/Bronchitis (J44.1) ☐ OSA (G47.33) ☐ Persistent Asthma (J45.40) **Length of Need:** ☐ Lifetime ☐ Months _____

## OXYGEN

☐ **Overnight Oximetry Test (Room Air)** ☐ **Capnography** ☐ **On O2** ☐ **On CPAP/BIPAP**

## OXYGEN EQUIPMENT PRESCRIPTION

**Home Oxygen_____ lpm/via nasal cannula & humidification prn/concentrator**

☐ O2 Mask **Sats:** _____

☐ Nocturnal O2 Only

☐ 24 Hours (with portable) ☐ Transfilling Device

☐ Conserving Device* ☐ Portale Concentrator

*RT to asses patient's need for conserving device. Tirate liter flow to keep $SaO_2$ greater or equal to 90%.

## SLEEP THERAPY PRESCRIPTION

☐ **CPAP** (E0601) _____$cm/H_20$ ☐ Auto Mode_____-_____ *Please include a copy of patients sleep study results with this request.

☐ **BIPAP** (E0470) ☐ Auto Mode_____-_____ **IPAP**_____$cm/H_20$ **EPAP**_____$cm/H_20$ Min **PS**_____$cm/H_20$ Max **PS**_____$cm/H_20$

☐ **BIPAP ST** (E0471) **IPAP**_____$cm/H_20$ **EPAP**_____$cm/H_20$ **Breath Rate**_____BPM, I Time(Ti) _____ Rise Time_____

☐ **BIPAP ASV** (E0471) **Max Pressure**_____$cm/H_20$ **EPAP**_____$cm/H_20$ **Max PS**_____$cm/H_20$ Min **PS**_____$cm/H_20$

**Breath Rate**_____BPM

☐ Heated Humidifier (E0562) ☐ Supplies (Mask, headgear, tubing, filter, cushions) _____LPM Oxygen Bled.In

## NEBULIZER PRESCRIPTION

☐ **Nebulizer Compressor** (E0570)

☐ **Nebulizer Supplies** (A7005, A7003)

☐ **Nebulizer Medication** to be forwarded to pharmacy

## MEDICAL EQUIPMENT

☐ **Walking Aids** ☐ Front Wheeled Walker ☐ Walker with Seat

☐ **Hospital Bed-Semi-Electric**

☐ **Wheelchair*** ☐ Standard

☐ **ELR's**

**Required Information**
**Height:** _____
**Weight:** _____

***PLEASE INCLUDE ANY SUPPORTING DOCUMENTATION**

| Patient Name: | NPI# |
|---|---|
| Physician's Signature: | Date: |

**Please Fax: This Prescription • Patients Demographics • Patients Insurance • Qualifying Chart Notes**