

Oxygen & Respiratory REFERRAL FORM

Phone: _____

To place an order, please complete and FAX to:

For use in AZ and other States as applicable

Patient Name: _____

Date of Birth: _____

RX Date: _____

Diagnosis: COPD (J44.9) Extrinsic Asthma (J45.20) Chronic Bronchitis (J42)
 Acute Bronchiolitis (J20.9) Chronic Obstructive Asthma (J44.9) Emphysema (J43.9)
 CHF (I50.9) Other: _____

Length of Need: _____ (If lifetime, use 99) Height: _____ Weight: _____

Oxygen LPM _____ via N/C Mask

Please Specify Usage: Continuous Nocturnal Rest Exercise

Please Specify Modality: Concentrator Portable Other _____

Conserving Device

(Note to ordering physician: before prescribing, please be aware that a conserving device is NOT intended for use during sleep or by patients who breathe greater than 40 breaths/minute or who fail to consistently trigger the device due to a weak inspiratory effort.)

Test Results: Pulse Oximetry/SaO2 _____ ABG/PaO2: _____

Date Tested: _____ Where Tested: _____ Test Condition: Nocturnal Rest Exercise

Nebulizer Compressor Non-Disposable Neb Kit (A7005 1 per 6 months)

Respiratory Services Overnight Oximetry to be performed on:

Room Air Oxygen at _____ LPM CPAP/BiPAP/APAP CPAP/BiPAP w/ Oxygen at _____ LPM

Comments/Other Orders: _____

Please provide face-to-face chart notes and test results that support medical necessity with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: _____ NPI: _____ Fax: _____

Physician's Signature: _____ Signature Date: _____

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS