OXYGEN THERAPY ORDER FORM

Please return completed form with patient's face sheet & applicable clinical notes to the fax number at the bottom of this page

Patient Name:	**Height:**_____ **Weight:** _____
Date of Birth:_____/_____/_____ ■ **M** ☐ **F**	**Diagnosis:** ☐ COPD ☐ CHF ☐ Pulmonary Hypertension ☐ Bronchiectasis ☐ Hypoxemia ☐ Other:_____; _____
Address: _____ _____	
Order Start Date:	

RENTAL ITEMS	**SUPPLIES**
E1390 ☐STATIONARY CONCENTRATOR	**A4615** ☐NASAL CANNULA
E1392 ☐PORTABLE OXYGEN CONCENTRATOR	**A4616** ☐TUBING
E0431 ☐PORTABLE SYSTEMS/TANKS	**E0555** ☐BUBBLE HUMIDIFIER

Oxygen Flow Rate: _____LPM Via Nasal Cannula

Frequency of Use (check all that apply): ▣ At Rest/Awake ■ During Exertion ■ During Sleep

Testing O2 Sat:	**Testing Date:**

____% At Rest on Room Air ____% With Exertion on Room Air ____% With Exertion on ____LPM Oxygen

Ordering Physician Information

Ordering Physician Name: (Print) _____	**Address:** _____ _____	**Phone #:** **Fax #:**
Ordering Physician Signature **X**_____	**Date:** _____/_____/_____	**NPI #:** **PECOS REGISTERED? ☐ Y / ☐ N**

***NOTE TO PHYSICIAN: THIS FORM WAS FILLED OUT ACCORDING TO INFORMATION WE RECEIVED FROM YOUR OFFICE AND/OR YOUR PATIENT. BY SIGNING THIS FORM YOU ARE CERTIFYING THAT YOU HAVE REVIEWED IT FOR ACCURACY AND THERE IS SUPPORTING DOCUMENTATION VERIFYING THIS INFORMATION IN THE PATIENTS PERMANENT MEDICAL RECORDS AND THAT INFORMATION IS AVAILABLE UPON REQUEST.**

PLEASE ENCLOSE ANY RELEVANT PROGRESS NOTES WHEN RETURNING THE FORM

DOME HOME CARE
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