

Prescription Form

Date: _____

Patient Information:

Pt name _____
Address _____
City _____ State _____ Zip _____
Phone _____

DOB _____ Male Female
Social Security _____
Alternate Phone _____
Emergency Contact _____

Insurance Information:

Medicare # _____
Medicaid # _____
Primary/Supplement _____
Phone _____ Insured Name _____
Plan/ID# _____ Group # _____

Physician Information:

Physician _____
NPI _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

For Physician Use Only

Rx for POX Testing:

- Pulse Oximetry Testing for Medicare Qualification
 Pulse Oximetry Testing for Private Insurance Qualification

Diagnosis Information:

DX _____
ICD-9 _____

Rx for Oxygen Therapy:

- Via nasal cannula Via Other _____
Liters per Minute _____ at Rest Respiratory Assessment PRN
_____ with Exertion •Pulse Oximetry Testing
_____ during Sleep •Titrate to keep SpO2 ≥90%
•OCD Assessment
Other instructions _____

Oxygen Test Information:

Test Location _____ Date _____
Test on room air: _____ at Rest Test on O2 at _____ lpm:
_____ with Exertion _____ with Exertion
_____ during Sleep _____ during Sleep
Other Comments _____

Rx for Sleep Therapy:

- CPAP Supplies
 CPAP _____ cwp CFlex/EPR Setting _____
 AutoPAP _____ cwp min - _____ cwp max
 BiPAP _____ / _____ cwp B/U Rate: _____
 O2 bleed in at _____ lpm PS RANGE: _____
 Heated Humidity
Other instructions _____

Sleep Therapy Test Information:

Sleep Study date _____
Location _____
AHI _____ Total Sleep Time _____
Other Comments _____

The anticipated length of need is:

- Lifetime (99) other _____

Rx for Nebulizer Therapy:

- DuoNeb _____ Albuterol _____
 Atrovent _____ Xopenex _____
 QID TID BID Q _____ hrs _____
Other instructions _____

Notes:

Any infections/special precautions? No Yes, _____

Date _____

Physician Signature _____