Oxygen One, Inc.
The Home Respiratory & Sleep Specialists

Five Element Order
Home Respiratory Equipment and Services

MR#:______________

Please complete entire form. All fields are required.

Patient: ____ DOB: ____________________________________

ICD10:____ ICD10:____________________________________

ICD10:____ ICD10:____________________________________

Stationary and Portable Home Oxygen Therapy including contents

Patient is mobile in the home: ☐ Yes ☐ No

Anticipated length of need is: ☐ Lifetime (99) ☐ **O**ther: _______ **If less than lifetime, further testing may be required.*

The prescription is for oxygen at:	**Method of delivery:**
_____ lpm at rest while awake	☐ Nasal Cannula
_____ lpm with exertion	☐ CPAP
_____ lpm during sleep	☐ Other: ____________

Additional: 1. Pulse Dose/OCD as appropriate 2. Pulse Oximetry Testing PRN 3. Titration to keep Sp02 $\geq$ 90%

Nebulizer Compressor for Aerosol Therapy (1 Permanent Nebulizer Kit and 2 Disposable Kits)

Anticipated length of need is: ☐ Lifetime (99) ☐ **O**ther: _______

Medication:	**Frequency:**	
☐ Duoneb 2.5 ml	☐ Q __________ hour	**PRN Orders are not covered by insurance*
☐ Albuterol 2.5 mg	☐ QD	
☐ Atrovent 0.5 mg	☐ BID	
☐ Xopenex 1.25 mg	☐ TID	
☐ Other ___________________	☐ QID	

Physician Name Printed: ____ **NPI:** _______________________

Physician Signature: ____ **Date:** _____________________

Physician Phone: ______________________________ **Physician Fax:** ___________________________________

Fax the following information to 262.521.2249

- ☐ **Five Element Order Form**
- ☐ **Insurance information/patient demographics**
- ☐ **Respiratory assessment qualifying testing for oxygen**
- ☐ **Physician signed documentation of face to face encounter discussing symptoms and medical necessity**

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