Respiratory Service Request

Phone: 800-287-0643 • Fax: 973-538-2703

***These fields MUST be completed**

PATIENT INFORMATION

***Patient Name:** _____ DOB: Height: _____ Wt:_____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Daytime Phone: _____

Patient E-mail Address: _____

SSN: _____ Diagnosis: _____

Primary Insurance Coverage: _____ ID: _____

Insured Name (if other than patient): _____ DOB:

Secondary Insurance Coverage: _____ ID: _____

Insured Name (if other than patient): _____ DOB:

RESPIRATORY SERVICES

Home O2 concentrator
Portable O2 tanks
w/ contents
O2 liter flow ____ LPM

Method of delivery:
☐ Nasal cannula
☐ Trach
☐ Oxygen mask

Duration of usage:
☐ Continuous
☐ With activity
☐ While sleeping

☐ Evaluate Patient for conserving device via pulse oximetry; dispense if qualifies

☐ Nebulizer and supplies:
Mask (1 per month)
Neb Kit (2 per month)
Filter (1 per month)

Medication: _____

☐ Overnight pulse-oximetry
☐ On room air
☐ On oxygen

CPAP @ _____ CM H2O
AutoPAP @ _____ –_____ CM H2O
BIPAP @ _____ /_____ CM H2O
BIPAP ST @ _____ /_____ CM H2O

Backup rate: _____

☐ Mask w/ Headgear (1 every 3 months / 1 every 6 months)
☐ Heated humidifier
☐ Chamber (1 every 6 months)
☐ Tubing (1 every 3 months)
☐ Filters (6 every 3 months)
☐ Other _____

Estimated length of need: _____ months (99 = lifetime)

***These fields MUST be completed**

PHYSICIAN INFORMATION

Referral's Name: _____ ***ORDER DATE:** _____

***Physician Name:** _____ Phone: _____

Address: _____ Fax: _____

_____ ***NPI:** _____

_____ Discharge Date: _____

Physician Signature: _____ ***Date:** _____

Rev. 04/15

Thank you for your order. We look forward to servicing your patient.