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 / refills
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

❑ Portable oxygen concentrator

❑ 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)
❑ Cushions (2 every month)
❑ Heated humidifier
❑ Chamber (1 every 6 months)
Tubing (1 every 3 months):
❑ Standard ❑ Climate line
Filters:
❑ Reusable (1 every 6 months)
❑ Disposable (2 every month)
❑ Chinstrap
❑ 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. 05/19

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