DOUBEK medical supply

TF: 800.368.2358
F: 708.293.1144
doubekmedical.com

Referral Name: _____

Referral #: _____

Fax to (708) 293-1144

Oxygen Written Order

PATIENT INFORMATION

Order Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Email Address: _____ Phone #: _____

Diagnosis: (ICD 10): _____

Duration: _____

PATIENT INSURANCE INFORMATION

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance _____

Insurance ID #: _____ Group # _____

It is not necessary to fill it out this section, if the order is accompanied by a copy of the patient's insurance card.

OXYGEN ORDER

☐ Concentrator

TYPE OF PORTABILITY

☐ Port Tanks (E) ☐ Portable Concentrator ☐ Homefill w/Port Tank ☐ Conserving Device

METHOD OF DELIVERY

Pulse Dose _____ LPM _____

Test Condition: ☐ Rest ☐ Exercise ☐ Sleep

EXERCISE OXYGEN ORDER

Results on room air before exercise: _____

Results on room air during exercise: _____

Results on O2 during exercise: _____

SLEEP OXYGEN ORDER

☐ If SpO2 ≤ 88% for more than 5 minutes initiate nocturnal oxygen at: _____ LPM, via:

- ☐ Nasal Cannula
- ☐ On CPAP _____ cm H2O
- ☐ On Bi-Level IPAP _____ cm H2O / EPAP _____ cm H2O

☐ Repeat Overnight Oximetry on oxygen _____ LPM in _____ days

☐ Saturation Study Attached ☐ Face to Face Attached

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING NEED FOR OXYGEN AND COPY OF QUALIFYING OXYGEN SATURATION TEST FROM PATIENT'S CHART.

PRESCRIBING PHYSICIANS INFORMATION

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Physician Phone #: _____ Fax #: _____