Oxygen & Respiratory REFERRAL FORM

For use in NV

Patient Name: **Date of Birth:** **RX Date:**

Diagnosis: ☐COPD (496.) ☐ Extrinsic Asthma (493.00) ☐ Chronic Bronchitis (491.20)
☐ Acute Bronchiolitis (466.0) ☐ Chronic Obstructive Asthma (493.20) ☐ Emphysema (492.0)
☐ CHF (428.0) ☐ Other: _____ _____ _____

Length of Need: _____ (If lifetime, use 99) Height: _____ Weight: _____

☐ **Oxygen** LPM _____ via ☐N/C ☐Mask

Please Specify Usage: ☐ Continuous ☐ Nocturnal ☐ Rest ☐ Exercise

Please Specify Modality: ☐ Concentrator ☐ Portable ☐ Other _____

☐ Conserving Device

(***Note to ordering physician**: before prescribing, please be aware that a conserving device is NOT intended for use during sleep or by patients who breathe greater than 40 breaths/minute or who fail to consistently trigger the device due to a weak inspiratory effort.)*

Test Results: Pulse Oximetry/SaO2 _____ ABG/PaO2: _____

Date Tested: _____ Where Tested:_____Test Condition: ☐ Nocturnal ☐ Rest ☐ Exercise

☐ **Nebulizer Compressor** ☐ Non-Disposable Neb Kit (A7005 1 per 6 months)

☐ **Respiratory Services** Overnight Oximetry to be performed on:

☐ Room Air ☐ Oxygen at___ LPM ☐ CPAP/BiPAP/APAP ☐CPAP/BiPAP w/ Oxygen at ____ LPM

Comments/Other Orders:

Please provide face-to-face chart notes and test results that support medical necessity with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: NPI: Fax:

Physician's Signature: Signature Date:

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS