Patient's Name_____

Patient's Address_____

Patient's Home Phone_____ Patient's Cell Phone_____

Patient's Date of Birth_____ Weight_____ Height_____

DIAGNOSIS (ICD 10 codes)

_____ _____ _____ _____

Start Date_____ **Length of Need**_____

OXYGEN/RESPIRATORY EQUIPMENT

_____LPM ☐ Oxygen Concentrator Other: _____ ☐ 24 Hour ☐ Nocturnal ☐ Other:_____

☐ Nasal Cannula Other:_____

☐ Portable Gas ☐ Conserving Device or Regulator Flow Setting:_____ ☐ Other:_____

Date of Test:_____ *(or attach test results)*

Saturation Levels—fill in only those that apply At Rest:_____ Nocturnal:_____

Walk Test—Rest:_____ Walk:_____ Walk with O2:_____

☐ Overnight Oximetry ☐ On Room Air:_____ ☐ On Oxygen:_____

☐ **NEBULIZER**

☐ Nebulizer Disposable Set (2 per month) Neb- ☐ ulizer Non-Disposable Set (1 per 6 months)

☐ Nebulizer Non-Disposable Filter (1 per 3 months) Neb- ☐ ulizer Disposable Filter (2 per 1 month)

SLEEP THERAPY

☐ CPAP _____ cmH2O Ramp:_____

☐ CPAP (Auto-Titrating) Minutes:_____ cmH2O Max:_____ cmH2O

☐ Bi-level without rate IPAP:_____ cmH2O EPAP:_____ cmH2O

☐ Bi-level with rate IPAP:_____ cmH2O EPAP:_____ cmH2O Rate:_____

Mask Interface:

☐ Patient's Mask of Choice (1 per 3 months) Or:_____

Accessories:

☐ Heated Humidifier ☐ Nasal Pillow (2 pair per month) ☐ Chinstrap (1 per 6 months)

☐ Cool Humidifier ☐ Full Face Mask Cushion (1 per month) ☐ Filter: Disposal (2 per month)

☐ Humidifier Chamber (1 per 6 months) ☐ Tubing (1 per 3 months) ☐ Filter: Non-Disp. (1 per 6 months)

☐ Nasal Mask Cushion (2 per month) ☐ Headgear (1 per 6 months) Oth- ☐ er:_____

PLEASE ATTACH THE FOLLOWING *(as applicable)*

☐ Test Results (Oximetry, ABG, Sleep Study) ☐ Patient Demographics ☐ Patient's Insurance Card(s)

☐ Face-to Face Visit Notes(from medical records of patient, documenting need and physician's assessment—with physician's signature and date)

Practitioner's Name(please print or stamp)_____

Address_____

Telephone_____Facsimile_____

NPI#_____Physician's Signature and Date:_____

1900 Apperson Drive, Salem – (540) 380-3383 – Fax (540) 380-3393
For Questions 24/7/365 Call (540) 380-5588
479 Piney Forest Road, Danville – (434) 797-2332 – Fax: (434) 793-3916

Please fax this form (or a prescription/order) with this information, and supporting documents to:

Commonwealth Home Health Care, Inc.
479 Piney Forest Road
Danville, Virginia 24540
(434)797-2332
FAX (434) 793-3916

Please contact us with any questions you may have about medical equipment referrals.