PROVIDENCE HOME MEDICAL EQUIPMENT		**Respiratory Prescription Referral Form**	PROVIDENCE Health & Services
6410 NE Halsey, Suite 500 Portland, OR 97213 Phone: (503) 215-4663 Fax: (503) 215-4011	**Salem Location:** 2508 Pringle Road Salem, OR 97302 Phone: (503) 585-4027		

Date:	**Ordering Contact:**	**Phone #:**	**Fax #:**

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**	
Address 1:	**Apt. #:**	**City/State/Zip:**	
Alternate Contact/Relationship:		**Alt. Phone #:**	
Primary Insurance Plan:	**Ins. ID#:**		**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**		**Group #:**
Subscriber Name/Relationship:			**Subs. DOB:**
Following Phys. (if diff. than Ordering):		**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Length of Need: ☐ Life Time ☐ Other: **ICD-10 Code(s):**

Oxygen Saturations for Home Oxygen System (Stationary and/or Portable)

➡ **Required:** Prescribed Oxygen Frequency @ ____ lpm*

____% at rest on Room Air — *≤ 88% on room air at rest?* ➡ ☐ Continuous via Nasal Cannula

____% activity on Room Air — *> 88% on room air at rest; ≤ 88% on room air w/ activity?* ➡ ☐ w/ Activity via Nasal Cannula

____% activity on O2 @ ___ lpm* — **if ≥ 4 lpm, most recent sats on O2 @ 4 lpm:* ____ **% Testing Date:** _____

≤ 88% for > 5 mins. sleep or *decrease of 5% from baseline?* ➡ ☐ Nocturnal via ☐ Nasal Cannula *or* ☐ Bleed-in w/ PAP

Testing Location: _____ **Testing Date:** _____

Testing Performed: ☐ Within 30 days prior to order (outpatient) *or* ☐ Within 2 days of discharge from inpatient admission (hospital, SNF)

☐ **Oxygen Conserving Device (OCD)**

➡ **Required:** Titrate to > _____ %

Note: a Respiratory Therapist visit will be scheduled to ensure saturation levels are maintained on device. A standard portable system will be dispensed until an OCD evaluation can be completed.

☐ **Overnight Oximetry** performed on ☐ Room Air *or* ☐ Oxygen @ _____ lpm *and/or* ☐ PAP System

☐ **Nebulizer & Supplies** ☒ Administration kits (disposable: 2 per mo./non-disposable: 1 per 6 mos.) ☒ Filters (2 per mo.)
☒ Aerosol mask (1 per mo.) Medication to be administered by nebulizer: _____

☐ **Respiratory Suction & Supplies** ☐ Tracheal *or* ☐ Oral *Oral suction supplies:* ☒ Suction bottle (4 per mo.)
☒ Filters (2 per mo.) ☒ Suction tubing (8 per mo.) ☒ Yankauer suction tip catheters (4 per mo.)

☐ **Pulse Oximeter** ☐ Finger monitor *or* ☐ Continuous tabletop monitor and replacement sensor probes (max. 4 per mo.)

☐ **Cough Assist & Supplies** ☒ Replacement mask (1 per 3 mos.) ☒ Filters (2 per mo.) ☒ Tubing (1 per 6 mos.)

Comments:

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN SIGNATURE AND DATE]

Physician Printed Name: **NPI#:**

➡ **Physician Signature: X** ➡ **Date:**

Please attach supporting documentation & fax to 503-215-4011

THANK YOU FOR CHOOSING PROVIDENCE HOME SERVICES