DME & Respiratory REFERRAL FORM

Phone:

To place an order, please complete and FAX to:

For use in AZ and other States as applicable

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

Diagnosis: ☐COPD (J44.9) ☐ Extrinsic Asthma (J45.20) ☐ Chronic Bronchitis (J42)
☐ Acute Bronchiolitis (J20.9) ☐ Chronic Obstructive Asthma (J44.9) ☐ Emphysema (J43.9)
☐ CHF (I50.9) ☐ Other: _____ _____ _____

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

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

☐ **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

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

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

Durable Medical Equipment

☐ Semi-Electric Hospital Bed ☐ Bariatric Hospital Bed
☐ Standard Wheelchair ☐ Lightweight Wheelchair ☐ Heavy Duty Wheelchair ☐ Power Wheelchair
☐ Transport Chair ☐ Elevating Leg Rests ☐ Fully Reclining Wheelchair
☐ Other Wheelchair Accessory: _____ _____ _____ _____
☐ Front Wheeled Walker ☐ 4 Wheeled Walker w/Seat ☐ Heavy Duty Walker
☐ Compressor & Heater ☐ Chest Percussor ☐ Cough Stimulator ☐ Ventilator
☐ Ultra-Violet Light Therapy ☐ Home Glucose Monitor ☐ Commode ☐Heavy Duty Commode
☐ Patient Lift ☐Bone Growth Stimulator ☐ Lymphedema Pump & Sleeve
☐ TENS Unit ☐2 TENS Leads (A4595 1 per/mo) ☐4 TENS Leads (A4595 2 per mo)

Comments/Other Orders:

Please provide face-to-face chart notes 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

Rev. 09-16-15