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) Weight: Height: 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: Portable Other ☐ Concentrator 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: Oxygen at___ LPM ☐ Room Air ☐ 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 ☐ Home Glucose Monitor ☐ Heavy Duty Commode ☐ Ultra-Violet Light Therapy ☐ 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: