

DME & Respiratory REFERRAL FORM



Phone:

Account Manager:

To place an order, please complete and FAX to:

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