ROTECH OXYGEN & MEDICAL EQUIPMENT
7897 SW JACK JAMES DR. #E, STUART FL. 34997
772-223-1208 FAX 772-223-1210 TOLL FREE FAX 866-285-7755

PHYSICIAN ORDER

Name: _____ DOB: _____ Gender: ☐Male ☐Female Date: _____

Address: _____ City: _____ St: _____ Zip: _____ Phone: _____

Estimated LON: 99 Months (lifetime) **OR** _____ Face-to-Face Needs Assessment Date: _____ Height: _____ Weight: _____

Diagnosis:

☐ALS (G12.21) ☐Chronic Bronchitis (J41.0) ☐Hypoxemia (R09.02) ☐Acute Resp Fail (J96.00)
☐Asthma, Extrinsic (J45.20) ☐COPD (J44.9) ☐Lung Cancer (C34.90) ☐Resp Failure, Unspecified (J96.90)
☐Asthma (J45._____) ☐CVA (I63.50) ☐OSA (G47.33) Other: _____
☐Central Sleep Apnea (G47.31) ☐Emphysema (J43.9) ☐Pneumonia (J18.9) Other: _____
☐CHF (I50.9) ☐Hypoventilation Syndrome (G47.35) ☐Pulmonary Fibrosis (J84.10) Other: _____

RESPIRATORY EQUIPMENT

☐O_2 Concentrator (E1390) **OR** _____
☐O_2 Portable Gaseous System (E0431)
(incl oxygen contents) **OR**: _____

Dosing Instructions:
_____ LPM via Nasal Cannula **OR** ☐Mask **OR** ☐PAP Device **OR** Invasive Vent
Continuous **OR** ☐Exercise/Exertion **OR** ☐Hours of Sleep Only
☐Conserving Device

☐Nebulizer Compressor (E0570)w/ disp filter (2 per 1 mo) and reusable filter (1 per 3 mos) (if app) & w/disp admin set (2 per 1 month) + neb set (2 per 1 mo) **OR** w/☐Mask (1 per 1 mo) + Neb Set (2 per 1 mo); **OR** w/☐Reusable Admin Set (1 per 6 mos). Medication Used in Nebulizer: _____

SLEEP THERAPY

☐CPAP (E0601): _____ cmH_2O Ramp: _____
☐Auto CPAP (E0601): Min: _____ cmH_2O Max: _____ cmH_2O
☐BiPAP (E0470): IPAP: _____ cmH_2O EPAP: _____ cmH_2O
☐RAD w/BU (E0471): IPAP: _____ cmH_2O EPAP: _____ cmH_2O Backup Rate: _____
☐ASV (E0471) Max Press: _____ cmH_2O EPAP Min: _____ cmH_2O EPAP Max: _____ cmH_2O
PS Min: _____ cmH_2O PS Max: _____ cmH_2O Backup Rate: _____

Mask Interface: ***(choose only 1 interface – substitution permitted)***

☐Nasal Mask (1 per 3 months) (A7034) & Nasal Mask Cushion (2 per month) (A7032)
☐Nasal Pillow Mask (1 per 3 months) (A7034) & Nasal Pillow Cushion (2 pair per month) (A7033)
☐Full Face Mask (1 per 3 months) (A7030) & Full Face Mask Cushion (1 per month) (A7031)
☐Oral Mask Interface (1 per 3 months) (A7044) & Oral Mask Cushion (2 per month) (A7028)
☐Combo Oral/Nasal Mask Interface (1 per 3 months) (A7027) with Oral Cushion (2 per month) (A7028) & Nasal Pillows (2 per month) (A7029)

Accessories:

☐Heated Humidifier (E0562)
☐Humidifier (Passover) (E0561)
☐Humidifier Chamber (1 per 6 months) (A7046)
☐Standard Tubing (1 per 3 months) (A7037)
☐Heated Tubing (1 per 3 months) (A4604)
☐Headgear (1 per 6 months) (A7035)
☐Chinstrap (1 per 6 months) (A7036)
☐Filter: Disposable (2 per month) (A7038)
☐Filter: Non-disposable (1 per 6 months) (A7039)

DIAGNOSTIC

☐Overnight Oximetry on Room Air **OR**
☐Sleep Screening w/AHI
☐Other: _____

WHEELCHAIR & ACCESSORIES

☐Standard (K0001)
☐Lightweight (K0003)*
☐Heavy Duty (K0006)*
☐Extra Heavy-Duty (K0007)*
Unable to self-propel in standard wheelchair
☐General Use Seat Cushion (E2601) & Back Cushion (E2611) ≤22"wide
☐General Use Seat Cushion (E2602) & Back Cushion (E2612) >22"wide
☐Elevating Leg Rests (pair) (K0195)
☐Heel Loops (E0951) (x2 for pair)
☐Wheel Lock Extensions (E0961) (x2 for pair)
☐Anti-tippers (E0971) (x2 for pair)
☐Safety Belt (E0978)

HOSPITAL BED & ACCESSORIES

☐Semi-Electric[1](E0261) w/Therapeutic Foam Mattress (E0184)
Other: _____
☐Trapeze (free standing) (E0940)
☐Trapeze (bed attached) (E0910)
☐Patient Lift (E0630)

[1]***In addition to meeting fixed height bed criteria, patient's medical record must document condition requires frequent and/or immediate changes in body position.***

AMBULATORY AIDS

☐Walker (Folding) (E0135)
☐Walker (Folding w/ Wheels) (E0143)
☐Walker (w/Wheels + Seat) (E0143 +E0156)
☐Walker (Heavy Duty w/Brakes) (E0147)
☐Walker (Heavy Duty) (E0148)
☐Bedside Commode (E0163)
☐Crutches (alum or non-wood) (pair) (E0114)
☐Cane (E0100)
☐Quad Cane (E0105)

OTHER EQUIPMENT: _____

ATTACH THE FOLLOWING (AS APPLICABLE)

☐Test Results (oximetry, ABG, Sleep Study)
☐Patient Demographics Sheet and Ins. Card
☐Physician's Notes *(from medical record documenting face-to-face needs assessment and expected benefit from equipment ordered above; physician must sign and date notes)*

PHYSICIAN INFORMATION

Name: _____ NPI: _____ Phone: **772-678-7043** Fax: **772-403-2379**

Address: **1980 SE OCEAN BLVD.** City: **STUART** State: **FL** Zip: **34996**

Physician Signature: _____ Date: _____