



PHONE: 1.800.344.1550 FAX: 1.844.317.9377
EMAIL: orders@chcsolutions.com

OXYGEN ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Language Pref.: English Spanish Other: _____ Patient cannot accept deliveries on the following days?
Mon Tues Wed Thurs Fri Sat
Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ Secondary Diagnosis ICD-10 Code: _____
*Non-Specified Codes will not qualify for Primary Diagnosis

Please answer questions below.

Date of most recent assessment of patient's oxygen carrying capacity (ABG or % SAT): ____/____/____
(Must be within 30 days of this request and must be preformed on room air)

a. Arterial Blood Gas PO2 _____ mm HG Oxygen Saturation Test _____ % saturation

Has it been established that disease is severe and will improve with this therapy? Yes No

Have alternative treatment measures to improve cardiopulmonary function been considered/tried and have been documented as ineffective? Yes No

Was Patient in a chronic stable state at time ABG or saturation performed? (Not during an actual illness) Yes No

What were the test conditions?:
_____ At rest and/or during activities of daily living _____ During exercise _____ During sleep

Name of Physician/Provider Performing test: _____
*If patient does not qualify on room air at rest (not 88% or below), then they need to be tested three ways.
_____ On room air at rest _____ On room air with exertion _____ With exertion with oxygen

Please answer questions below if in first question PO2 >= 56-59mm HG or Oxygen Saturation >= 89%.

Are there other conditions that would help qualify the patient for oxygen? (Check all that apply.)
 Dependent edema due to Congestive Heart Failure Cor Pulmonale or Pulmonary Hypertension _____
 Hematocrit greater than 56% Other _____

Patient is already on oxygen therapy _____ months _____ years

What type of equipment are you requesting for the patient?
 Both Stationary and Portable: For patient requiring O2 while at rest and mobile
 Portable Only: Is patient mobile within the home? _____ (must have stationary set-up)

What is the highest flow (LPM) ordered for this patient?
 LPM _____ (fill in amount) Less than 1 LPM
*If an LPM of >4 is ordered, enter recent test results taken while on 4 LPM
Date of Test: ____/____/____ Arterial Blood Gas PO2 _____ mm HG Oxygen Saturation Test _____ % saturation

What is the route of administration? Nasal Cannula Mask Trach Other _____

What is the duration? Exertion Continuous Other _____

Order Date: ____/____/____

Length of Need: _____ months (numeric form only)

REFERRAL INFORMATION Ref #: _____

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? Phone Fax Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____)____-____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.