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CONTINUUM CONNECT 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

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 89% 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?
 Portable Only: Is patient mobile within the home? \_\_\_\_\_  Both Stationary and Portable: For patient requiring O2 while at rest and mobile

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

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.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_