CHC SOLUTIONS, INC.

FAX: 1.844.317.9377
EMAIL: dmeorders@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	**Secondary Diagnosis**
ICD-10 Code: _____	**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 PO_2 _____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 Preforming 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 PO_2 > = 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 O_2 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 PO_2 _____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, 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.

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.