CHC SOLUTIONS, INC.

FAX: 1.844.317.9378
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TRACHEOSTOMY ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact Name/Phone Number: _____

DIAGNOSIS/INSURANCE

Primary Diagnosis	**Secondary Diagnosis**
ICD-10 Code: _____	**ICD-10 Code:** _____

TRACHEOSTOMY SUPPLIES:

Trach Tube: Style: _____ Size: _____ ☐ Cuffed ☐ Uncuffed ☐ Fenestrated ☐ Non Fenestrated

☐ Trach Inner Cannula: Quantity per day: _____

☐ Trach Care Kits (1 per Day) Quantity per day: _____

☐ Trach Tube Holder Quantity per day: _____

SUCTION MACHINE SUPPLIES:

Suction Machine: ☐ Suction Machine Stationary ☐ Suction Machine Portable

☐ Suction Catheter Size: ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18 Quantity per Month _____

☐ Suction Canister (2 per month)

☐ Suction Tubing (2 per month)

☐ Oral Suction (Yankauer) (2 per month)

☐ Filter Quantity _____

OXYGEN SUPPLIES:

☐ Both Stationary and Portable: Liter Flow: _____ Duration: _____

Please include baseline saturations on room air _____

HUMIDITY SUPPLIES:

☐ 50psi Compressor O_2 Liter Flow: _____	☐ Corrugated Tubing (100ft)
☐ Humidifier Bottle (2 per month)	☐ Trach Drain Bag (2 per month)

NEBULIZER SUPPLIES:

☐ Nebulizer with 50psi Compressor

☐ Trach Mask

PULSE OXIMETRY SUPPLIES:

☐ Pulse Oximeter

☐ Pulse Oximeter Probes (4 per Month)

Pulse Oximeter Settings: Low Sa O_2: _____ High HR: _____ Low HR: _____

MISC. SUPPLIES:

Gauze ☐ 2x2 ☐ 4x4 Quantity per Month _____

Gloves (2 boxes per month) ☐ Small ☐ Medium ☐ Large ☐ X-Large

Other:

Order Date: _____/_____/_____ **Refils: _____** **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.