ADVANCED MEDICAL SOLUTIONS

800-248-2229 OPTION 1 FAX TO: 800-552-9443

Reset Form

OXYGEN DETAILED WRITTEN ORDER FOR DELIVERY

Patient Name: _____ Account #_____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone:_____ Mobile:_____ ☐ **Face Sheet/Demographics Faxed**

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order: _____**

DIAGNOSIS (Check appropriate diagnosis below) Length of Need in Months _____ (99 = Lifetime)

☐ CHF ☐ Pulmonary Hypertension

☐ COPD ☐ Respiratory Failure

☐ Emphysema

☐ Other: _____

TESTING

☐ Overnight Oximetry

TREATMENT TYPE (Check appropriate treatment below)

☐ 24 - Hour Oxygen (continuous) E1390/E1392

_____ LPM

☐ Nocturnal Oxygen (at night) E1390

☐ Portable (w/activity) E1392

Pulse Flow (Conserving Device) Setting _____ Via Nasal Cannula

☐ Portable Oxygen Tanks E0431

☐ Other: _____

PRESCRIBING PHYSICIAN

Name & Credentials: _____ NPI Number: _____

Telephone: _____ Fax: _____

Signature: _____ Signature Date: _____

(Stamped signature not accepted)