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(330) 545-6700	(724) 962-5670	(330) 395-7252
Fax (330) 545-5555	Fax (724) 962-5673	Fax (330) 373-1190

RESPIRATORY E-Z SCRIPT

Please fax your patient's insurance and demographic information along with this form.

Date: ____________________

Patient Name: ____

Patient Phone #: ______________________________________

Address: ____

Diagnosis/Diagnosis Code: ______________________________

Ordered By: __________________________________

Height: ____________________ Weight: ____________

Duration of Need: ______________________________

❑ AEROSOL TREATMENT

❑ Portable Nebulizer / Supplies
❑ Nebulizer / Supplies SN ______________________

Supplies for Nebulizer
Nebulizer Administration Kit
Aerosol Mask
Filters Disposable/Reusable
Medication Dispensing Fee

❑ Albuterol 2.5mg / 3ml
❑ Ipratropium 0.5mg / 2.5ml
❑ Duoneb / 3ml
❑ Pulmicort 0.25mg / 2ml

____ Other: ____

Directions: ❑ Daily ❑ BID ❑ TID ❑ QID ❑ Q4H ❑ Q6H

Number of samples given: ____________________________

Refills ____________________

❑ OXIMETRY

❑ **Standard Oximetry Recording** - Pulse oximetry recording to be performed during normal activities and sleep while on room air. (Includes room air at rest, activity and nocturnal).

❑ **Special Oximetry Studies** - Pulse oximetry recording to be performed during: *(check all that apply)*
❑ Rest ❑ Normal Activity ❑ Sleep **Oxygen Used:** ❑ On Room Air ❑ On Oxygen at: ________ LPM

❑ OXYGEN

❑ Oxygen Therapy - Evaluate for oxygen system that maintains most active lifestyle. Selection criteria based on 5th Consensus Oxygen Conference recommendations for portability. Evaluate oxygen saturations for pulse dose delivery to mainatin Sat at greater than or equal to 90%.

Via: ❑ Nasal Cannula ❑ Mask ❑ Related Supplies

Use at: _____ Liters/Minutes ❑ Stationary
_____ Hours/Day ❑ Portable/OCD - titrate to keep Sat greater than or equal to 90%

Evaluate pulse ox as needed for shortness of breath and at discontinuation of therapy.

Tested on: ❑ Room Air ❑ Oxygen _____ LPM TestDate: ____________________ TestFacility: ________________

PaO_2 _____ mmHg **Performed:** ❑ Rest ❑ Exercise ❑ Sleep

SaO_2 _____ %

If over 4 LPM PaO_2 _____ mmHg on 4 LPM
or SaO_2 _____ % on 4 LPM

Date: ________________________
Location: ________________________

❑ SLEEP EQUIPMENT

(Please fax diagnostic & titration sleep report)

❑ CPAP / Supplies at _____ cm H_2O

Sleep study performed? ❑ Yes ❑ No Facility: ________________
Date Performed: ________________

❑ BiPAP / Supplies at _____ IPAP _____ EPAP
❑ Back up rate (BiPAP ST)
❑ Humidifier ❑ Heated ❑ Cool
❑ O_2 bled in at _____ LPM

❑ **Supplies for Sleep Equipment:**
Chinstrap Mask Headgear Cushion
Pillows Tubing Chinstrap Filters Disposable/Reusable

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: ______________________________ DATE: _____/_____/_____

Printed Name: ______________________________ Address: ______________________________

Phone: ____________________ NPI #: ________________ City/State/Zip: ______________________________

Revised: 9-5-08