BOARDMAN MEDICAL SUPPLY
BMS
COMPANY, INC.
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(By Appointment Only)

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(330) 395-7252
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RESPIRATORY E-Z SCRIPT

****Please fax your patient's insurance information, demographics and chart notes with this form.****

Start Date: _____ Acct #:_____

Patient Name: _____

Patient Phone #: _____

Address: _____

Diagnosis/Diagnosis Code: _____

DOB: _____

Ordered By: _____

Height:_____ Weight:_____

Duration of Need:_____

AEROSOL TREATMENT

❑ Portable Nebulizer E0570
❑ Nebulizer E0570 SN _____
Supplies for Nebulizer

❑ Neb kit reusable (A7005)	1 every 6 mo.
❑ Neb kit disposable (A7003)	2 every mo.
❑ Neb filter (A7013)	2 every mo.
❑ Aerosol Mask (A7015)	1 every mo.

For required documentation purposes, please fill out the section below:

Medication _____

Frequency _____

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
_____ Hours/Day

❑ Stationary
❑ 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 Test Date: _____ Test Facility: _____

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

SaO_2 _____ %

If over 4 LPM PaO_2 _____ mmHg on 4 LPM Date: _____

or SaO_2 _____ % on 4 LPM Location: _____

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: 4-26-16