

QUICK SCRIPT

Our family serving yours since 1987

Patient Name: _____ **Phone/Cell #** _____ **DOB:** _____

Address: _____ **Ins #** _____ **Ht** _____ **Wt** _____

Diagnosis: _____ **ICD-10:** _____

Diagnosis: _____ **ICD-10:** _____

LON if less than a lifetime : _____ (1-99, 99= lifetime)

Required Documentation: Face to Face Evaluation Oximetry Results
 Copy of demographic information? Yes No Copy of insurance information? Yes No

Oxygen

Concentrator:

✍ **Please select a liter flow:**
 _____ Lpm continuous via nasal canula
 _____ Lpm @ night _____ LPM w/exertion

O2 Sat: _____ % rest/room air sleeping
 O2 Sat: _____ % with exertion
 O2 Sat: _____ % with exertion on Oxygen

Date of Test: ___ / ___ / ___ By: _____

Portable Oxygen (may include):
 Regulator & Tanks Conserving Device & Mini Tanks
 POC (may provide once patient completes POC evaluation and is determined appropriate therapy)

PAP Machines

Cpap _____ cmh2o **Bipap** ___ / ___ cmh2o
 Heated Humidifier O2 Bleed In @ _____ Lpm
 Auto 4-20 for 30 days, then change to average CPAP pressure.

Unless otherwise indicated below a **Nasal Mask** (up to 1 per 3 mos) **w/ replacement cushions/pillows** (up to 2 per mo) is prescribed

Full Face Mask (up to 1 per 3 mos) with replacement face mask interface (up to 1 per mo)

Tubing (check one): **Standard** (up to 1 per 3 mos) -or-
 Heated (up to 1 per 3 mos)
 Filters (disposable up to 2 per mo--non-disposable up to 1 per 6 mos)
 Headgear (up to 1 per 6 mos) Chin Strap (up to 1 per 6 mos)
 Water Chamber (up to 1 per 6 mos)

Pulse Oximetry

Spot Check Overnight Oximetry
 O2@ _____ Lpm On room air Other _____
 3 part testing (available for all insurances except Medicare)

Ambulation Devices

Std Wheelchair Lightweight Wheelchair
 Heavy Duty Wheelchair 16" seat 18" seat
 20" seat 22" seat 24" seat 26" seat
 Elevating leg rest Brake Extensions
 Seat & back cushion Anti tippers Seat Belt

Walker Wheels Seat

Nebulizer (including disposable kits up to 4 per month, non-disposable kits up to 1 per month 6 months and filters up to 2 per month)

Physician's Orders: Enroll in the Breathe at Home Program which includes the following and will be completed as needed for up to one year. This program is for patients who are not currently on oxygen service.

- Overnight Pulse Oximetry Testing
- Patient Education (including but not limited to): COPD Overview, Exercise, Nutrition, Medication, Smoking Cessation

Beds & Accessories

Semi-electric hospital bed w/ gel overlay
 Trapeze Eggcrate Gel overlay APP&P
 3 in 1 Commode Patient Lift Other:

By signing below, this validates the prescription above & indicates the patient has been informed that DASCO will contact them regarding of this referral.

X _____ / _____ / _____
Physician's Handwritten Signature **Date** **NPI**

Physician's Printed Name **Address** **Phone**

Phone: 614.392.4355 Toll Free: 1-800-892-4044 Fax: 614.304.6189