DASCO HOME MEDICAL EQUIPMENT 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)

Oxygen

Concentrator: ***(please enter liter flow)***

2 Lpm via NC unless otherwise specified by ordering provider below:

____Lpm via NC

□ continuous via nasal cannula with portability

□ @ night

□ w/ exertion with portability

□ O_2 Bleed in @ _____ Lpm

Testing: ***(please attach copy)***

O_2 Sat: _____ % □ rest/room air □sleeping □on PAP/NIV

O_2 Sat: _____ % □ with exertion

O_2 Sat: _____ % □ with exertion on oxygen

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

□ ***Portable Oxygen*** ***(may include):***

Regulator & Tanks

Conserving Device & Mini Tanks

**For portability, office notes must indicate the patient is mobile within the home.*

□ POC *(may provide once patient completes POC evaluation & is determined appropriate therapy).*

Pulse Oximetry

□ Spot Check □ Overnight Oximetry

□ O_2 @ ____Lpm □ On room air □ Other _____

□ 3 part testing *(available for all insurances during COVID pandemic)*

-6 MWT to include titration on O_2 up to >90% sat

□ Overnight POX testing up to 6 times a year

□Breathe Easy Program

☑ Physician's Orders: Enroll in the Breathe Easy 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 with a severe chronic lung disease.

- Overnight Pulse Oximetry Testing up to 6 times a year
- Patient Education *(including but not limited to):* COPD Overview, Exercise, Nutrition, Medication, Smoking Cessation

□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 Easy Program which includes all of the above.

PAP Machines

□ **CPAP**_____ cmh2o □ **BiPAP** ____ /____ cmh2o

□ **Auto PAP** ___-___cmh2o □ **BiPAP ST** ___/___ RR:___

□ **Auto ASV:** Min EPAP____ Max EPAP ____

Min PS ____ Max PS ____ BR: Auto

□ O2 Bleed In @ _____ Lpm ☑ Heated Humidifier

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)*

Ambulation Devices

□ Wheelchair (including anti-tippers & heel loops):

• Standard □ Lightweight □ Heavy Duty

Seat Width: □ 16" □ 18" □20" □ 22" □ 24" □ 26"

□ Elevating leg rests □ Brake Extensions

□ Seat & back cushion □ Seat Belt

□ Wheeled Walker

Beds & Accessories

□ Semi-electric hospital bed w/ gel overlay

□ Trapeze □ Gel overlay □ APP&P

□ 3 in 1 Commode □ Other: _____

Continuous Glucose Monitors

□ FreeStyle Libre 2 Sensors *(check one):* □ 1 Unit (30 day supply) or 30units

□ FreeStyle Libre 2 Reader □ 3 Units (90 day supply) or 90 units

□ FreeStyle Libre 3 Sensors* *(check one):* □ 1 Unit (30 day supply) or 30units

**Non-Medicare patients only* □ 3 Units (90 day supply) or 90 units

□ GEMCORE360 Transparent Thin Film Dressing - Bag of 10

If patient receives test strips & lancets monthly, please note the date of the last order (if applicable): _____

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

X _____ _____/_____/_____ _____

Physician's Handwritten Signature ***Date*** ***NPI***

_____

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

Toll Free Phone: 800.892.4044 Fax: 800.979.1956

Print Reset