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Ensuring quality care from the first breath of life until the last; we'll be there every step of the way.

AEROFLOW HEALTHCARE

PATIENT

Patient Name:_____ Phone:_____
DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female
Height:_____ Weight:_____
Address:_____
City:_____ State:_____ Zip:_____
1st Insurance:_____ Phone:_____
Policy #:_____ Group #:_____
2nd Insurance:_____ Phone:_____
Policy #:_____ Group #:_____
Alternate Contact:_____ Phone:_____
Relationship:_____

PRESCRIBER

Prescriber's Name:_____ NPI #:_____
Phone:_____ Fax:_____
Address:_____
City:_____ State:_____ Zip:_____

Diagnosis:_____ **Face-to-Face Visit Date:**_____
Order Date:_____ **Start Date:**_____ **Length of Need:**_____
99 months=Lifetime

HOME OXYGEN @ ____ LPM;

O2 SAT ____ % SAT Date ____
☐ Cont (E1390 & E0431) ☐ Nocturnal (E1390)
Conserving Test (if patient qualifies for conserver, please dispense)

POSITIVE AIRWAY PRESSURE THERAPY

☐ CPAP (E0601) ☐ BIPAP (E0470) ☐ BIPAP w/ Backup (E0471)
Pressure Settings ____ cmH2O
☐ Auto-Titrate CPAP/BIPAP (5-20cmH2O)

VENTILATOR

☐ Invasive (E0463) ☐ Non-Invasive (E0464)
☐ TITRATE TO COMFORT AND EFFECTIVENESS

OVERNIGHT OXIMETRY (799.02/R0902)

For nocturnal hypoxemia due to COPD or other lung disease
☐ On Room Air ☐ On CPAP ☐ On BIPAP
☐ On O2 ☐ On Ventilator
☐ If overnight oximetry is abnormal, follow clinical recommendations and begin treatment via oxygen or move forward with sleep study 95806, G0399, G0400 and Diagnosis 327.23/G47.33

SLEEP STUDIES

☐ UNATTENDED SLEEP STUDY (327.23/G47.33)
☐ If sleep study is abnormal, follow sleep MD recommendations and begin treatment (if warranted) via CPAP/BIPAP/Oxygen
☐ ATTENDED SLEEP STUDY/POLYSOMNOGRAPHY (PSG)

HOME NEBULIZER THERAPY (E0570)

Medication ____ (or generic equivalent)
Frequency ____
Refills ____

COUGH ASSIST (E0482)

☐ Manual ☐ Automatic
Settings:
Inhale pressure ____ cmH20
Exhale pressure ____ cmH20
IE Time:
Inspiratory Time ____ sec
Expiratory Time ____ sec

HOSPITAL BED

☐ Semi-Electric (E0260) ☐ Full-Electric (E0265)
☐ Bariatric (E0303) ☐ Fixed Height (E0250)

Support Surface

☐ Gel Pressure Pad (E0185)
☐ Low Air Loss Mattress (E0277)
☐ Other (please specify) ____

MANUAL WHEELCHAIR

☐ Standard (K0001) ☐ Hemi (K0002) ☐ Lightweight (K0003)
☐ High Strength Lightweight (K0004) ☐ Heavy Duty (K0006)
☐ Extra Heavy Duty (K0007)

Cushions

☐ Standard (E2601) ☐ Gel (E2603)
☐ Positioning (E2605) ☐ Gel with Positiong (E2607)

Comments: _____

ONLY APPLIES TO MEDICARE UNATTENDED SLEEP STUDY ORDERS: I, the undersigned, understand that by completing the form and signing below that I am ordering a Home Sleep Test for patient listed above. I also understand that Medicare guidelines require a face-to-face evaluation for Obstructive Sleep Apnea to be documented in the patient's chart prior to a home sleep test and that this test will be done by an Independent Diagnostic Testing Facility (IDTF).

Physician's Signature:_____ Date:_____