Sutter Care at Home Timberlake Respiratory Care & Home Medical Equipment Order Form

Fax: 888.635.6301 • Phone: 800.281.1764

PATIENT INFORMATION (OR DEMOGRAPHIC SHEET)

Patient Name: ______________________ DOB: __________

Address: ______________________ City: __________ Zip Code: __________

Phone Number: ______________________ Height: __________ Weight: __________

Primary Insurance: ______________________ Secondary Insurance: __________

Primary Insurance ID Number: ______________________ Secondary Insurance ID Number: __________

Diagnosis (Please enter ICD-10 code)

❑ Asthma _______ ❑ COPD _______ ❑ Hemiplegia _______ ❑ Osteoporosis _______

❑ CAD _______ ❑ CVA _______ ❑ Hypersomnia w/Sleep Apnea _______ ❑ Pneumonia _______

❑ CHF _______ ❑ Emphysema _______ ❑ Obstructive Sleep Apnea _______ ❑ Rheumatoid Arthritis _______

❑ Other: ______________________ **Length of Need** (99=Lifetime): ______________________

OXYGEN & RESPIRATORY EQUIPMENT

❑ **Overnight Oximetry** ❑ **Room Air** *(3rd party testing may be used – per insurers' guidelines)*

❑ Oxygen Liters per Minute: ______________________

Hours per Day: ______________________ *(no PRN for duration)*

O2 Portability: ______________________

❑ Pulse Oximeter x 1 Month for Pt. to Titrate Pulse Dose – Keep SAO2 at ________% or above

❑ **Nebulizer Compressor**

Medication(s) Prescribed *(required for billing)* ______________________

❑ Other: ______________________

O2 Testing Conditions

❑ O2 SAT or PO2 (ABG): __________

Rest __________ %RA

Exercise __________ %RA

2L of O2 __________ %

Sleep (w/ 2L of O2) __________ %

Sleep __________ %RA

Date of Test: __________

Please include chart notes with the oxygen saturations and the conditions of testing.

SLEEP THERAPY EQUIPMENT & SERVICES

❑ CPAP **Setting:** ______ cmH2O (4-20 cm)

❑ Auto CPAP **Settings:** ______ – ______ cmH2O (4-20 cm)

❑ Bi-Level **Settings:** IPAP ______ cmH2O, EPAP ______ cmH2O (4-25 cm)

❑ Bi-Level **ST Settings:** IPAP ______ cmH2O, EPAP ______ cmH2O (4-30 cm), Rate ______ (off, 1-30 bpm)

❑ Auto Bi-Level **Settings:** IPAP ______ cmH2O, EPAP ______ cmH2O (4-25 cm) Pressure support: ______ cmH2O

❑ Heated Tubing

❑ O2 Bleed _______ LPM (if applicable)

❑ Other ______________________

For AHI 5<14, please check any/all that apply:

❑ Hypertension

❑ Pulmonary Hypertension

❑ Impaired Cognition, Mood Disorders

❑ Cardiac Arrhythmias

❑ Ischemic Heart Disease, History of Stroke

❑ Excessive Daytime Sleepiness

CPAP Supplies

❑ Filters/Tubing

❑ Mask

❑ Fit to Patient Comfort

❑ Other __________

Please include sleep study. Payers also require chart notes documenting the incidence of sleep issues prior to the sleep study.

HOME MEDICAL EQUIPMENT

❑ Front Wheeled Walker ❑ Quad Cane ❑ Cane ❑ Crutches ❑ Wheelchair ❑ Lightweight Wheelchair ❑ Hospital Bed

❑ Trapeze ❑ Alternating Pressure Pump & Pad ❑ Patient Lift ❑ Free Standing Trapeze ❑ Bedside Commode

❑ Other: ______________________

Please include current chart notes that substantiate the need for each item ordered.

PHYSICIAN INFORMATION

Physician Name (please print): ______________________ Phone: __________

CA License Number: __________ NPI Number __________ Fax: __________

Signature: ______________________ Date: __________