APRIA HEALTHCARE®

Respiratory/Sleep Therapy Order Form

Your Apria Representative ______________________

Branch location ______________________

Phone ______________________

FAX: 888-492-0010

REFERRAL SOURCE

Office name ______________________ Office contact name ______________________

Date ____________ Phone ______________________ Fax ______________________

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name ______________________ DOB ____________
Last First

Home phone ______________________ Mobile phone ______________________

Diagnosis ICD-9
- ☐ 496 COPD ☐ 428.0 CHF ☐ 492.8 Emphysema ☐ 491.9 Chronic bronchitis ☐ 327.23 OSA
- ☐ 491.20 Obstructive chronic bronchitis ☐ Other ____________ ☐ Other ____________

Oxygen

Estimated length of need ______ **months (99 = lifetime)**

Date of test __________ Location ______________________

☐ Stationary O_2 at ________ LPM
 ☐ Continuous ☐ Nocturnal

☐ Portable O_2 system

Route of delivery:
 ☐ Nasal cannula ☐ Via PAP ☐ Other ____________

Please report qualifying SAT results: (required)

SpO_2% RA resting ______________________

Ambulation only: (three tests required for Medicare)

SpO_2% RA resting ______________________

SpO_2% RA ambulating ______________________

SpO_2% on O_2 ambulating ______________________

Nocturnal testing only:

SpO_2% $\leq$ 88% for ______ hours ______ minutes

Lowest SpO_2 ____________

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING NEED FOR OXYGEN AND COPY OF QUALIFYING OXYGEN SATURATION TEST FROM PATIENT'S CHART

Oxygen Conserving Device

Please choose ONE of the following. OCDs do not deliver liters per minute. Please prescribe a setting.

☐ OCD at setting (1 – 6) _______

☐ Evaluate my patient for OCD system. Titrate the oxygen setting to achieve an SpO_2 of $\geq$ 90% at rest and during activities of daily living via pulse oximetry; and setup on the appropriate conserving device.

Overnight Oximetry

☐ Overnight oximetry testing for qualifying purposes (CPT 94762)

☐ on room air ☐ on oxygen at _______ LPM

☐ on CPAP _______ cm H_2O

☐ on Bi-level IPAP _______ cm H_2O / EPAP _______ cm H_2O

Nebulizer

☐ Small volume nebulizer/compressor and all nebulizer circuits, filters, masks and related supplies

☐ Medication ______________________

Frequency ______________ Dose ____________

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING NEED FOR NEBULIZER FROM PATIENT'S CHART

Sleep Therapy

Estimated length of need ______ **months (99 = lifetime)**

Date of the scheduled re-evaluation appointment with prescribing physician (no sooner than the 31st day and no later than the 91st day after setup): ____________

☐ **CPAP** _______ cm H_2O (4–20 cm H_2O) Ramp time _______

☐ **Bi-level** IPAP _______ cm H_2O / EPAP _______ cm H_2O

☐ **Auto Bi-level** Max IPAP _______ cm H_2O
 Min EPAP _______ cm H_2O (4–25 cm)*
 Ps min _______ cm H_2O (0–8 cm)
 Ps max _______ cm H_2O (Ps min -8 cm)

*EPAP must be lower than IPAP

☐ Patient to choose mask to comfort, or
 Mask type ______________ ☐ S ☐ M ☐ L

☐ Heated humidification

☐ Sleep study date ______________ ☐ AHI or RDI _____

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING SIGNS AND SYMPTOMS OF OSA, DIAGNOSTIC SLEEP STUDY AND TITRATION STUDY (IF APPLICABLE) FROM PATIENT'S CHART

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the items prescribed.

Print prescriber's name ______________________ **NPI #** ____________

Prescriber signature ______________________ **Date** ____________

©2014 Apria Healthcare Group Inc.