Portable Oxygen Concentrator Order Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name _____ DOB _____
LAST FIRST

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes. Please enter the appropriate diagnosis and write in the code. Ranges will not be accepted.

Code _____ Description _____

Code _____ Description _____

Length of need _____ **months** (99 = lifetime) **Total hours per day of oxygen use** _____

Is the patient mobile within the home? ☐ Yes ☐ No

To set up the above-named patient on a portable oxygen concentrator for medical use, please complete the sections below and fax this form back to Apria.

SETTINGS

Select only <u>one</u> setting option:

☐ Portable oxygen concentrator at pulse setting _____ at rest _____ with activity
Note: The pulse settings do not correlate to LPM of oxygen.

☐ Have an Apria clinician titrate the patient (if selected, same day POC setup may not be available in some areas). Titrate the portable oxygen concentrator setting to achieve an SpO_2 of ≥ 90% (or _____%) at rest and with activity via pulse oximetry.

EQUIPMENT ORDERED

Select only <u>one</u> equipment option:

☐ **For patients requiring a POC that will be used continuously 24/7 as both the stationary and portable oxygen system.**
- Provide portable oxygen concentrator with pulse dose technology, via nasal cannula.
- Provide emergency backup cylinder

Settings: _____ LPM at rest _____ LPM with activities _____ LPM during sleep

☐ **For patients requiring O2 entrainment into a medical device OR for patients not tolerating nocturnal use on a POC.**
- Provide portable oxygen concentrator with pulse dose technology, via nasal cannula for daytime use.
- Provide stationary oxygen concentrator for nocturnal use via nasal cannula or PAP/NIV device

Settings: _____ LPM at rest _____ LPM with activities _____ LPM during sleep

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 records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____

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