Capnography and Overnight Oximetry 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 check the appropriate diagnosis and write in the code. Ranges will not be accepted.

- ☐ _____ Chronic Bronchitis (J41.0 – J42)
- ☐ _____ Emphysema (J43.0 – J43.9)
- ☐ _____ Chronic Obstructive Pulmonary Disease (J44.0 – J44.9)
- ☐ _____ Acute and Chronic Respiratory Failure (J96.10 – J96.92)
- ☐ _____ Other: _____

• Capnography and overnight oximetry (M #891658) via eIDTF

- ☐ Room air
- ☐ Oxygen @ _____ LPM
- ☐ On PAP (CPAP or Bi-Level) at current setting of _____

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** _____

ACIS ID _____ CPU _____

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