APRIA®

Portable and Stationary 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, ALONG WITH A SIGNED AND DATED COPY OF THE FACE-TO-FACE EVALUATION AND/OR TEST RESULTS FROM THE PATIENT'S CHART

PATIENT INFORMATION

Patient Name _____ (LAST) _____ (FIRST) DOB _____

Home Phone _____ Mobile Phone _____ Patient Height _____ MBI/INS ID # _____

Patient Address: Street _____ City _____ State _____ Zip _____

DIAGNOSIS ICD-10: Diagnosis codes require a corresponding ICD-10 code and must be corroborated in the patient's medical record.

DX Code _____ Description _____

LON_____ months (99 = lifetime) **Is the patient mobile within the home?** ☐ **YES** ☐ **NO**

ROUTE OF DELIVERY

☐ Nasal Cannula
☐ Bleed In via _____ Device
☐ Other: _____

TESTING

Date of test: _____ **Location:** _____

Test Results for Oxygen at Rest while awake(required)**:**

SpO_2% RA resting: _____

Test Results for Oxygen with Ambulation (/exercise)

(Medicare requires all three tests to be performed during the same testing session):

SpO_2% **RA** resting: _____
SpO_2% **RA** ambulating: _____
SpO_2% on **O_2** ambulating: _____

Test Results for Nocturnal Oxygen:

During Sleep:
SpO_2% ≤ 88% for _____ hrs._____ mins.
Lowest SpO_2 _____

EQUIPMENT & SETTINGS

OXYGEN TYPE:

Stationary oxygen: ☐ **24/7 Use** ☐ **Nocturnal**

Portable Oxygen: **Continuous** **Pulse Dose (OCD / POC/TOC)**

Liter flow: O_2 at rest _____ lpm O_2 with ambulation _____ lpm
O_2 for nocturnal _____ lpm

Pulse Dose Setting: (Select only one setting option)

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

☐ Apria to titrate POC/OCD settings to maintain an SpO2 of ≥ 90% (or_____ %) at rest and with activity via pulse oximetry.
Note: Same day POC setup with titration may not be available in all locations

POC USE DIRECTIONS
(Required for POC order)

Select only one equipment option:

☐ **POC or TOC used as both stationary & portable device**
- Emergency backup cylinder settings:
  _____ at rest _____ with activities _____ during sleep

☐ **POC + Stationary for nocturnal oxygen when**
- Patients requiring O2 entrainment into a medical device OR
- For patients not tolerating nocturnal use on a POC Concentrator settings at night: _____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 _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____ **Phone** _____

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