Oxygen Order Form

Patient Name _____ DOB_____ Member ID_____

Diagnosis

J44.9 COPD____ I50.9 CHF____ J43.9 Emphysema____ J44.0 Chronic Bronchitis____

J84.10 Pulmonary Fibrosis___ U07.1 COVID_____ J45.50 Severe Persistent Asthma____

J45.51 Severe Persistent Asthma w/ acute exacerbation____ Other (specify)_____

Prescription: Oxygen Therapy

Select Equipment:

- ☐ E1390 Concentrator
- ☐ E0431 Portable Tank

Select Mobility:

Walked into Facility independently ____ Other____

Uses Walker ____

Liter Flow: 2LPM____ 3LPM ____ 4LPM ____ Other ____

Nocturnal _____ **Continuous** _____

Via: Nasal Cannula ____ Mask ____ Trach ____ Bleed in ____

Length of Need: 99____ Other ____

Oximetry: **Date of Testing:** _____

☐ If at rest	ABG or Saturation On Room Air
☐ If during exercise (all 3 sats required) ☐ Length of test 5 mins___ 6 mins___ 10 mins___	Resting Sat: Exercise Sat: Exercise on O2 Sat:
☐ If During sleep	Saturation at or below 88% for 5 Min _____ Or Drop PO2 >10mmHG or > 5% Sat drop at least 5 min, signs and symptoms
☐ If under group 2 Criteria: SpO2= 89% with qualifying secondary diagnosis	Dependent Edema due to congestive heart failure____ Hematocrit greater than 56% ___ Cor Pulmonale or Pulmonary Hypertension ____

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

DME Company: Axis Medical Equipment & Supply, LLC

NPI: 1417926106 Phone: 972-889-2947 Fax: 972-767-4762