APRIA HEALTHCARE®

Respiratory/Sleep Therapy Order Form

Your Apria Representative _____

Branch location _____

Phone _____

Fax _____

REFERRAL SOURCE

Office name Abington Neurological Associates Office contact name _____

Date _____ Phone 215-957-9250 Fax 215-957-9254

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name _____ (Last) _____ (First) DOB _____

Home phone _____ Mobile phone _____

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

☐ _____ Obstructive Sleep Apnea (G47.33) ☐ _____ Congestive Heart Failure (I50.20 – I50.43) ☐ _____ Chronic bronchitis (J41.0 – J42)

☐ _____ Emphysema (J43.0 – J43.9) ☐ _____ Chronic Obstructive Pulmonary Disease (J44.0 – J44.9)

☐ _____ 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 PA ☐ 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% ≤ 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 ≥ 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/APAP ☐ on Bi-level IPAP

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): _____ (optional)

☐ **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) — EPAP must be lower than IPAP

Ps min ____ cm H_2O (0–8 cm) Ps max ____ cm H_2O (Ps min -8 cm)

☐ **Auto CPAP** Min EPAP ____ cm H_2O / Max EPAP ____ cm H_2O

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

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

Prescriber signature _____ **Date** _____