# Oxygen Order Form

adapthealth

**Equipment Order Status:** ☐ New Patient ☐ Change in Order ☐ Renewal ☐ Discontinue

**Patient Information:**

Patient Name:_____ Date of Birth:_____/_____/_____ Order Date:_____/_____/_____

Patient Phone:_____-_____-_____ Diagnosis:_____ Length of Need:_____(99=Lifetime)

Address:_____

City:_____ State:_____ Zip Code:_____

**Oxygen Conserving Device Evaluation Order:** ☐ **Please check here if not applicable**

Please evaluate the above patient for an oxygen conserving device. Evaluation to include a pulse oximetry at rest and with activities of daily living. Maintain oxygen saturation levels at or above _____ % (if left blank, default percentage will be 90%), while on an oxygen conserving setting range of 1 - 5. If patient qualifies for the oxygen conserving device, please check off **one** of the following systems:

☐ **Standard OCD Regulator with Tanks**

☐ **Oxygen Concentrator:** Oxygen at: _____liters per minute

☐ Nasal Cannula ☐ Simple Mask (>5lpm only) ☐ Other: _____ ☐ Humidification ☐ Continuous ☐ With Exertion ☐ Nocturnal use

☐ **Portability: Portable Gaseous Oxygen System**

☐ E Tanks ☐ M6 Tanks ☐ Other: _____

**Qualifying Testing Criteria:**

Testing MUST be documented in the medical record & sent separately. **Date of Qualifying Test:** _____/_____/_____

1. O2 SAT on Room Air at rest _____% (if 88% or lower, stop here)
2. O2 SAT on Room Air with Exercise (88% or lower) _____%
3. O2 SAT on _____Liters of O2 with Exercise _____%

**PRN or "as needed" is not recognized by insurance, must be continuous or nocturnal* **Nocturnal testing can only be used to qualify for nocturnal O2, not continuous***

**Referring Practitioner Certification:**

Letter and Certificate of Medical Necessity: As the referring practitioner, I certify that the above prescribed order is medically necessary based on my diagnosis and is part of my overall treatment plan for my patients. In my professional opinion, the equipment and/or supplies I have prescribed for my patient is reasonable and necessary for accepted standards of medical practice and treatment of my patient's condition and has not been prescribed as "convenience equipment".

**Name:**_____ **Signature:**_____

**Date:**_____ / _____ / _____ **NPI:**_____ **Your signature confirms the accuracy of the information provided on this form*