Written Order Prior To Delivery / Detailed Written Order

adapthealth

Territory Manager:_____

Phone: _____-_____-_____ Fax: _____-_____-_____

Email: _____

Contact: 844-740-4093

Fax: 833-208-2313

Patient Information:

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

Patient Phone:_____-_____-_____ Diagnosis:_____

Referral Information:

Facility Name:_____ Facility Contact:_____

Order Date:_____ / _____ / _____ Order Confirmation:_____

Oxygen Therapy Equipment & Settings / Nebulizer Equipment:

1. Stationary Oxygen Concentrator Frequency E1390 Select One:
   ☐ 8-10 Hours Nocturnal ☐ 24 Hours Continuous ☐ Setting: _____ LPM Via Cannula & Tubing
2. Portable Oxygen System Requires Qualifying Daytime Testing Select One:
   ☐ Homefill K0738 ☐ Portable POC Oxygen Concentrator
3. Portable Setting Select One:
   ☐ Conserving Device Setting of: _____ or ☐ Continuous Flow of: _____
4. ☐ AdaptOne E1390 & E1392
   24 hours(continuous) setting: _____ LPM via cannula & tubing, POC with Conserving Device setting: _____
5. ☐ Nebulizer E0570 with Reusable Nebulizer Kit (A7005, 1/6 mos.) ☐ Other
6. Length of Need: ☐ Lifetime:_____ (99=Lifetime) ☐ Other: _____ Months

Sleep Therapy Equipment & Supplies:

1. ☐ E0601 CPAP:_____ cmH_2O (4-20 cmH_2O)
2. ☐ E0601 Auto Adjusting CPAP with settings of:_____ cmH_2O to:_____ cmH_2O (*4-20 cmH_2O)
3. ☐ E0470 Bi-Level IPAP: _____cmH_2O (*4-25 cmH_2O) EPAP:_____ cmH_2O (*4-25 cmH_2O)
4. ☐ E0470 Auto Adjusting Bi-Level Max IPAP:_____ cmH_2O Min EPAP: _____ cmH_2O PS: _____ (0-10 cmH_2O)
   Alternate PS setting: PS Min: _____ (0-8 cmH_2O) PS Max:_____ (0-8 cmH_2O) ***IPAP & EPAP RANGE: 4-25 cmH2O; EPAP must be lower than IPAP**
5. ☐ E0471 Advanced Bi-Level Max Pressure:_____cmH_2O Backup Rate:_____
   EPAP: Min_____cmH_2O Max:_____cmH_2O Pressure Support: Min:_____ Max:_____ Tidal Volume:_____
6. ☐ Heated Humidifer E0562 ☐ Humidifier Chamber (A7046, 1/6 mo)
7. ☐ Fit Full Face Mask (A7030, 1/3 mo) / Cushions (A7031) ☐ Fit Nasal Mask A7034, 1/3mo) / Cushions (A7032)
   ☐ Fit Nasal Mask (A7034, 1/3mo) / Pillows (A7033)
8. ☐ Tubing (A7037, 1/3mo) or ☐ Heated Tubing (A4604, 1/3mo)
9. ☐ Disposable filters(A7038, 2/mo) ☐ Reusable filters(A7039, 1/6mo) ☐ Headgear (A7035, 1/6mo) ☐ Chin Strap(A7036,1/6mo)
10. ☐ Respironics or ☐ Resmed
11. ☐ Lifetime:_____ (99=Lifetime) ☐ Other: _____ Months

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** _____ **Signature Date:**_____/_____/_____

Order Date:_____/_____/_____ **NPI** _____

**Your signature confirms the accuracy of the information provided on this form*