Fitzsimmons

Home Medical Equipment

A Division of Fitzsimmons Surgical Supply, Inc.

RESPIRATORY ORDER FORM

Phone (888) 402-9855 | Fax (844) 348-9633

PATIENT INFORMATION

PLEASE FAX A COPY OF PATIENT FACE SHEET WITH ORDER

Patient Name	Patient DOB	Order Date

OXYGEN THERAPY

TO QUALIFY, PT. MUST BE SEEN & EVALUATED BY THE PHYSICIAN AND TESTING PERFORMED WITHIN 30 DAYS PRIOR TO SETUP

☐ Oxygen Concentrator → ☐ Portable Gaseous Oxygen System*

→ *If Portable System Selected, evaluate for conserving device and titrate via oximetry to maintain $SpO^2 \geq 90\%$ at rest & w/ ambulation

☐ Continuous (*24 hrs*) ____LPM ☐ Nocturnal (*8-10 hrs*) ____LPM ☐ Exercise Only ____LPM

☐ Nasal Cannula ☐ Mask ☐ Inline w/ PAP Device ☐ Other _____

REQUEST DIAGNOSTIC TESTING BY INDEPENDENT TESTING FACILITY

☐ Third Party Overnight Oximetry Only → ☐ Room Air ☐ On O^2 at ____LPM ☐ On PAP at ____CWP

AEROSOL THERAPY

☐ Nebulizer w/Neb Kits (2 per mo.) & Aerosol Mask (1 per mo.) **LENGTH OF NEED _____ MONTHS (*99 = LIFETIME*)**

VEST THERAPY

☐ High Frequency Chest Wall Oscillation Air-Pulse Generator System **LENGTH OF NEED _____ MONTHS (*99 = LIFETIME*)**

RECOMMENDED PROTOCOL		**OR**	**CUSTOM PROTOCOL** (IF OTHER THAN RECOMMENDED)	
Treatments Per Day	2		Treatments Per Day	
Minutes Per Treatment	30		Minutes Per Treatment	
Frequencies/Intensities	(soft) 5 – 20 Hz (intense)		Frequencies/Intensities	
Minimum Usage Per Day	2		Minimum Usage Per Day	

SLEEP THERAPY

PLEASE FAX SLEEP STUDY & INITIAL FACE TO FACE EXAM NOTES WITH ORDER

LENGTH OF NEED _____ MONTHS (*99 = LIFETIME*)

☐ CPAP w/ Heated Humidifier at → ____CWP

☐ BiPAP w/ Heated Humidifier at → IPAP _____ EPAP _____ Back up Rate (if applicable) _____

☐ Full Face Mask System* or ☐ Nasal Interface Mask System* ☐ Chin Strap (1 per 6 mos.) ☐ Heated Tubing (1 per 3 mos.)

***Mask System Includes:** *Mask 1 per 3 mos., Headgear 1 per 6 mos., Tubing 1 per 3 mos., Cushions or Pillows 2 per mo., Disp. Filters 2 per mo., Water Chamber 1 per 6 mos., Reusable Filter 1 per 3 mos.*

PHYSICIAN INFORMATION

Physician Name	NPI
Physician Signature	Signature Date