BellevueHealthcare

RESPIRATORY ORDER FORM

FAX TO: 425-467-6661

Customer: Date of Birth:

Address:

City: State: Zip:

Phone: Email:

Please attach the following as applicable:

☐ Patient demographics ☐ Copy of Patient's Insurance card ☐ Test results (Oximetry, ABG, Sleep Study)

☐ Physician's Note: Signed and dated note from patient's medical records documenting requirement for equipment as well as physician's assessment of expected benefit from the equipment ordered.

☐ Oxygen Therapy

Test Date: ____/_____/____

Diagnosis: _____

Testing Facility: _____

Length of Need: _____ (1-99, 99=Lifetime)

Testing Conditions and Results (check one):

Liter Flow: _____ LPM Continuous via Nasal Cannula

☐ At Rest - SpO2: _____% or PaO2:_____ mmHg

Other (please specify) _____

☐ SpO2: Exercising: ____ % Exercising w/ O2: _____%

☐ Portable O2 (specify): _____

☐ Nocturnal: Include Overnight Oximetry Results

☐ Conserving Device: _____ LPM or Titrate liter flow to achieve SpO2 greater than: _____

☐ CPAP

Diagnosis: _____

Length of Need: _____ (1-99, 99=Lifetime)

CPAP Pressure: _____ (4 to 20 cm H2O)

CPAP Auto Pressure: Min_____ Max_____ (4 to 20 cm H20)

Ramp Time: ☐ YES ☐ NO

Humidification: ☐ COOL ☐ HEATED ☐ NONE

Date of Sleep Study: _____

Testing Facility: _____

☐ BIPAP

Patient tried and failed CPAP? ☐ YES ☐ NO

Diagnosis: _____

Length of Need: _____ (1-99, 99=Lifetime)

Inspiratory Pressure: _____ (5 to 30 cm H2O)

Expiratory Pressure: _____ (4 to 29 cm H2O)

Rate: (Bi-level S/T only): _____

Humidification: ☐ COOL ☐ HEATED ☐ NONE

Date of Sleep Study: _____

Testing Facility: _____

Mask Type: ☐ Nasal Mask (1 per 3 mos) ☐ Nasal Pillow Mask (1 per 3 mos)
☐ Full Face Mask (1 per 3 mos) ☐ Check here for therapist choice or best fit

Accessories & Supplies:

☐ Heated Humidifier ☐ Nasal Mask Cushion (2 per mo) ☐ Filter: Disposable (2 per mos)
☐ Cool Humidifier ☐ Nasal Pillow Cushion (2 per mo) ☐ Filter: Non-Disposable (1 per 6 mos)
☐ Humidifier Chamber (1 per 6 mos) ☐ Full Face Mask Cushion (1 per mo) ☐ Chinstrap (1 per 6 mos)
☐ Headgear (1 per 6 mos) ☐ Tubing (1 per 3 mos) ☐ Other: _____

☐ Nebulizer Compressor - Small Volume

Diagnosis: _____ Length of Need: _____ (1-99, 99=Lifetime)

Accessories & Supplies: ☐ Nebulizer Kit Disposable (2 per mo) ☐ Aerosol Mask (1 per mo) ☐ Filers – Disposable (2 per mo)

☐ Nebulizer Compressor – Large Volume

Diagnosis: _____ Length of Need: _____ (1-99, 99=Lifetime)

Accessories & Supplies: ☐ Nebulize Cap ☐ Corrugated Tubing 100' Segment ☐ Trach Mask

☐ Trach Care Ki ☐ Trach Drainage Bag w/ Y Adaptor ☐ Trach Tube Holder

☐ NaCl Solution 5ml ☐ Sterile Water 1000ml ☐ Drain Sponges

☐ Suction Machine

Diagnosis: _____

Length of Need: _____ (1-99, 99=Lifetime)

Accessories & Supplies:

☐ Yankauer. Type:_____

☐ Tracheal Suction Tube. Size: _____

☐ Tubing - 72"

☐ Trach Tubes & Supplies

☐ Trach tube and inner cannula. Make/model: _____

☐ Laryngectomy tube. Make/model: _____

Completed by (please print):_____

☐ MD ☐ DO ☐ PA ☐ ARNP

*Authorized Signature: _____ Date:_____

**If completed by Physician Assistant, Nurse Practitioner, or if you are working under a physician's UPIN or NIP, please include the physician's information below.*

Physician Name: _____

UPIN: _____ NPI: _____

Physician's Address: _____

Physician's Phone: _____ Fax:_____

Please fax to your local Bellevue Healthcare location.

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