



DASCO HOME MEDICAL EQUIPMENT QUICK SCRIPT



Our family serving yours since 1987

Patient Name: _____ Phone/Cell # _____ DOB: _____

Address: _____ Ins # _____ Ht _____ Wt _____

Diagnosis: _____ ICD-10: _____

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Date prescribed: ____ / ____ / ____ LON if less than a lifetime : _____ (1-99, 99= lifetime)

Medicare Additional Documentation: Face to Face Evaluation Oximetry Results

Copy of demographic information? Yes No

Copy of insurance information? Yes No

Oxygen (& related supplies)

PAP Machines

**Please attach documentation from the physician's record of a face-to-face evaluation of the patient **

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____ lpm continuous (or) ____ hpd via nasal cannula

Cpap _____ cmh2o Bipap ____ / ____ cmh2o
 Heated Humidifier O2 Bleed In

O2 Sat: _____ % rest/room air sleeping

O2 Sat: _____ % with exertion

O2 Sat: _____ % with exertion on Oxygen

Unless otherwise indicated below a **Nasal Mask** (up to 1 per 3 mos) **w/ replacement cushions/pillows** (up to 2 per mo) is prescribed

Combination Oral/Nasal mask (up to 1 per 6 mos) with Replacement oral cushion & pillow (up to 2 per mo)

Full Face Mask (up to 1 per 3 mos) with replacement face mask interface (up to 1 per mo)

Filters (disposable up to 2 per mo~non-disposable up to 1 per 6 mos)

Headgear (up to 1 per 6 mos) Tubing (up to 1 per 3 mos)

Chin Strap (up to 1 per 6 mos) Water Chamber (up to 1 per 6 mos)

Date of Test: ____ / ____ / ____ By: _____

Portable Oxygen:

Regulator & Tanks

Conserving Device & Mini Tanks

Pulse Oximetry & Sleep Screenings Services

Ambulation Devices

Spot Check Sleep Screening Questionnaire

Overnight Oximetry Home Sleep Test

Medicare 3 part testing

Std Wheelchair Lightweight Wheelchair

Heavy Duty Wheelchair Elevating leg rest

20" seat 22" seat 24" seat 26" seat

Elevating leg rest Brake Extensions

Seat & back cushion Anti tippers Seat Belt

Walker Wheels Seat

Nebulizer (including disposable kits up to 4 per month, non-disposable kits up to 1 per month 6 months and filters up to 2 per month)

Physician's Orders: Enroll in the Breathe Easy Program which includes the following and will be completed every 5 months as long as the patient remains on DASCO's nebulizer and/or nebulizer supply service or the patient begins oxygen therapy.

• Overnight Pulse Oximetry Testing

• Patient Education (including but not limited to): COPD Overview, Exercise, Nutrition, Medication, Smoking Cessation

Beds & Accessories

Semi-electric hospital bed Patient Lift

Trapeze Eggcrate Gel overlay APP&P

3 in 1 Commode Other:

By signing below, this validates the prescription above & indicates the patient has been informed that DASCO will contact them regarding of this referral.

X _____ / _____ / _____
Physician's Handwritten Signature Date NPI

Physician's Printed Name

Address

Phone

Phone: 419.289.6489

Toll Free: 1-800-892-4044

Fax: 419.289.6506