

**Patient Name:** \_\_\_\_\_ **Phone/Cell #** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Ins #** \_\_\_\_\_ **Ht** \_\_\_\_\_ **Wt** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **ICD-10:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **ICD-10:** \_\_\_\_\_  
**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)

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

\_\_\_\_ lpm continuous (or) \_\_\_\_ hpd via nasal cannula

O2 Sat: \_\_\_\_\_ %  rest/room air  sleeping  
 O2 Sat: \_\_\_\_\_ %  with exertion  
 O2 Sat: \_\_\_\_\_ %  with exertion on Oxygen

Date of Test: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ By: \_\_\_\_\_

**Portable Oxygen:**

Regulator & Tanks  
 Conserving Device & Mini Tanks

### PAP Machines

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

**Cpap** \_\_\_\_\_ cmh2o  **Bipap** \_\_\_\_ / \_\_\_\_ cmh2o  
 Heated Humidifier  O2 Bleed In

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)

### Pulse Oximetry & Sleep Screenings Services

Spot Check  Sleep Screening Questionnaire  
 Overnight Oximetry  Home Sleep Test  
 Medicare 3 part testing

**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

### Ambulation Devices

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

### 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: 502.473.6287 Toll Free: 1-800-892-4044 Fax: 502.473.6289**