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)

***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

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

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)

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: 317.392.3760 Toll Free: 1-800-892-4044 Fax: 317.392.3782

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