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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LON if less than a lifetime : _____ (1-99, 99= lifetime)

Required Documentation: □ Face to Face Evaluation □ Oximetry Results

□ *Copy of demographic information?* □ *Yes* □ *No* □ *Copy of insurance information?* □ *Yes* □ *No*

Oxygen

Concentrator:

↙ **Please select a liter flow:**

____ Lpm continuous via nasal canula

____ Lpm @ night ____LPM w/exertion

O2 Sat: _____ % □ rest/room air □ sleeping
O2 Sat: _____ % □ with exertion
O2 Sat: _____ % □ with exertion on Oxygen

Date of Test: ___ / ___ / ___ By: _____

☐ **Portable Oxygen (may include):**

Regulator & Tanks Conserving Device & Mini Tanks

□ POC (may provide once patient completes POC evaluation and is determined appropriate therapy)

Pulse Oximetry

□ Spot Check □ Overnight Oximetry

□ O2@ ____Lpm □ On room air □ Other _____

□ 3 part testing *(available for all insurances except Medicare)*

□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 at Home Program which includes the following and will be completed as needed for up to one year. This program is for patients who are not currently on oxygen service.

- Overnight Pulse Oximetry Testing
- Patient Education *(including but not limited to):* COPD Overview, Exercise, Nutrition, Medication, Smoking Cessation

PAP Machines

□ **Cpap** _____ cmh2o □ **Bipap** ___ /___ cmh2o

☑ Heated Humidifier ☐ O2 Bleed In @ _____ Lpm

□ Auto 4-20 for 30 days, *then change to average CPAP pressure.*

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

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

Tubing ***(check one):*** ☐ **Standard** *(up to 1 per 3 mos)* **-or-**

☐ **Heated** *(up to 1 per 3 mos)*

☑ Filters *(disposable up to 2 per mo~non-disposable up to 1 per 6 mos)*
☑ Headgear *(up to 1 per 6 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 □ 16" seat □ 18" seat

□ 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 w/ gel overlay

□ Trapeze □ Eggcrate □ Gel overlay □ APP&P

□ 3 in 1 Commode □ Patient Lift □ 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