

PHYSICIAN ORDER FORM



HOME MEDICAL EQUIPMENT

FAX: 586-469-1703

PATIENT INFORMATION: Order Date: _____

Patient Name: _____

DOB: _____

Address: _____

Telephone #: _____

Alternate #: _____

Medicare #: _____ Other Insurance: _____

Group #: _____ Subscriber ID: _____

Patient Height: _____ Weight: _____ Length of Need: _____

DIAGNOSIS: OTHER: _____

- 496 COPD
- 493.90 Asthma
- 398.91 CHF
- NIDDM 250.00
- 492.8 Emphysema
- 491.2 Chronic Bronchitis
- 327.23 OSA
- IDDM 250.01

OXYGEN:

- Liter flow _____
- Hours / Day _____
- SaO2 (room air) _____
- Oxygen
- Portable
- Conserving Device

NEBULIZER / MEDICATIONS:

- Compressor / Nebulizer Kit
- Albuterol 0.083% 3ml unit dose
- Ipratropium Bromide 0.02% (Atrovent) unit dose
- Duoneb

Frequency: BID TID QID Q4H

Refills: 1YR Other _____

SLEEP APNEA:

- CPAP _____ cmH2O
- Bi PAP _____ IPAP _____ EPAP _____
- Heated Humidification
- Passover Humidification Chin Strap _____
- Mask _____
- Size _____

EQUIPMENT:

Other: _____

- Hospital Bed
 - Hoyer Lift
 - Wheel Chair
 - Walker
 - Bedside Commode
 - Bathroom on other level? YES / NO
 - Room Confined? YES / NO
 - Blood Glucose Monitor
 - Test Strips (qty 100)
 - Lancets (qty 100)
 - Daily Times Testing? 1 / 2 / 3 / 4
- *Questions in Red must be answered***

Physician Signature: _____

Date: _____

Physician's Name: _____

NPI#: _____

Phone Number: _____

PHONE TOLL FREE: 1-800-474-1484

Address: _____

www.breakthru.com

DO NOT STAMP

