Fax to:
(801) 728-3340

PETERSEN MEDICAL
BREATHE EASIER

Standard written order.

Patient name: _____

Diagnosis

_____ _____ _____ _____ _____

Start date: _____ Estimated length of need (# in months): _____ 1-99 (99=lifetime)

Oxygen/respiratory equipment

_____ LPM

☐ Oxygen concentrator Other: _____ ☐ 24 Hour ☐ Nocturnal Other: _____ ☐ Nasal cannula Other: _____
☐ Portability gax
☐ Conserving device flow setting: _____

Date of test: _____
Saturation levels-fill-in only those that apply At rest: _____ Nocturnal: _____
Walk test-Rest: _____ Walk: _____ Walk with O_2: _____

☐ Nebulizer
☐ Neb disp set (2 per 1 month)
☐ Neb non-disp filter (1 per 3 months)
☐ Neb non-disp set (1 per 6 months)
☐ Neb disp filter (2 per 1 month)

☐ Overnight oximetry

Sleep therapy:

☐ CPAP cmH_2O ramp: _____
☐ CPAP (Auto-titrating) Min: _____ cmH_2O Max: _____ cmH_2O
☐ Bilevel w/o rate IPAP: _____ cmH_2OEPAP: _____ cmH_2O
☐ Bilevel w/rate IPAP: _____ cmH_2OEPAP: _____ cmH_2O rate: _____

Mask interface: (choose only 1 mask interface)

☐ Nasal mask (1 per 3 months) ☐ Nasal pillow mask (1 per 3 months) ☐ Full-face mask (1 per 3 months)

Accessories:

☐ Heated humidifier
☐ Humidifier chamber (1 per 6 months)
☐ Nasal Mask cushion (2 per month)
☐ Nasal pillow cushion (2 pair per month)
☐ Full-face mask cushion (1 per month)
☐ Tubing (1 per 3 months)
☐ Headgear (1 per 6 months)
☐ Chinstrap (1 per 6 months)
☐ Filter: Disposable (2 per month)
☐ Filter: Non-disposable (1 per 6 months)
☐ Other: _____

Please attach the following (as applicable)

☐ Test results (Oximetry, ABG, Sleep study) ☐ Patient demographics sheet ☐ Copy of patient's insurance card

☐ Physician's Note (from medical records of patient, documenting requirement for equipment as well as physician's assessment and expected benefit from the equipment ordered above. Physcians are required to sign and date notes.)

Practitioner name: _____

Address: _____ Phone: _____ NPI: _____

Date of face-to-face visit prior to ordering this respiratory item: _____ Practitioner signature: _____ Date: _____