OXYGEN ORDER

Physician Order & Documentation Form

Plan of Treatment

Advanced Diagnostic Solutions, Inc.
Fast! Efficient!! Courteous!!!

Phone: (352) 293-2810 Fax: (727) 264-2117

Order Date: ____ / ____ / _____

Patient Name: _____ DOB: ____ / ____ / _____

Ordering Physician: _____ PCP: _____

Pulmonary Diagnosis: _____ Duration of Need: LIFETIME: 99

****PHYSICIAN PROGRESS NOTE DOCUMENTING NEED MUST ACCOMPANY THIS FORM****

Stationary: ○ Concentrator- E1390

Portable: ○ Gas- E0431 or K0738 ○ Portable Concentrator - E1392

Contents: ○ Gas - E0443

Mode of Delivery: ○ Nasal Cannula ○ Oxygen Mask (Only if 4L or greater) ○ Related Supplies

PLEASE CHOOSE ONE OF THE OPTIONS BELOW:

○ Continuous Oxygen: Room Air Resting PaO_2 (<55%) _____mmHg **OR** SaO_2 (≤88%) _____%

○ Nocturnal Oxygen: Room Air while sleeping PaO_2 (<55%) _____mmHg **OR** SaO_2 (≤88%) _____%
Test Date: ____/____/_____ Test Facility: Advanced Diagnostic Solutions Inc. (Medicare Certified IDTF)

○ Oxygen for Activity: ****Documentation of the below 3 Pulse Ox values required****

1. SaO2 RA Resting (≤88%) _____ %
2. SaO2 with Activity (≤88%) _____ %
3. SaO2 with Activity & Oxygen (>88%) _____ %

Oxygen Level Testing Performed: ***Must be within 2 days of discharge***

Test Date: ____ / ____ / _____ Test Facility: _____

Liter Flow Ordered: _____ No. of Hours / Day: _____

*****NOTE: Medicare and Medicaid will not accept O2 prescribed as PRN*****

If > 4 LPM ordered: PO2_____mmHg on 4 LPM and/or_____% O2 sat on 4 LPM

Physician Notes

I certify that the medical information above is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's NPI: _____ License Number: _____

Physician's Signature: **X**_____ Date: ____ / ____ / _____

(Signature and Date Stamps are Not Acceptable)