Oxygen Therapy Prescription

FOR USE BY PHYSICIANS AND OXYGEN PROVIDERS

Patient Name: _____ Phone: _____ DOB: _____

Ordering Physician: _____ Phone: _____ FAX: _____

DIAGNOSIS

○ COPD – 496	○ Hypoxemia – 799.02
○ Pneumonia – 486	○ Interstitial Lung Disease – 515
○ Congestive Heart Failure (CHF) – 428.0	○ Atelectasis V18.0
○ Cor Pulmonale – 416.9	○ Post-op: _____
○ Obstructive Sleep Apnea – 780.53	○ Other: _____

QUALIFYING VALUES

Note: O_2 SAT (SpO_2 or SaO_2) must be <89% and/or PO_2 must be <55 mm Hg at rest, during exercise, and/or nocturnally.
If O_2 SAT = 89% OR PO_2 = 55-59, must document CHF, cor pulmonale, or polycythemia.

Initial	60- to 90-day verification	Annual verification
Date of test: ___/___/___	Date of test: ___/___/___	Date of test: ___/___/___
O_2 SAT: _____% *or* PO_2: _____mm Hg	O_2 SAT: _____% *or* PO_2: _____mm Hg	O_2 SAT: _____% *or* PO_2: _____mm Hg
○ resting ○ exercise ○ nocturnal	○ resting ○ exercise ○ nocturnal	○ resting ○ exercise ○ nocturnal

INITIAL O_2 SET-UP RECOMMENDATIONS

Recommended flow rate (check continuous and/or nocturnal and circle recommended L/min for each)

○ Continuous: 1 2 3 4 5 6 7 8 9 10 L/min

○ Nocturnal: 1 2 3 4 5 6 7 8 9 10 L/min

Is pulsed portable system needed? ○ yes ○ no (If unsure, choose yes.)

Recommended delivery system

○ Per oxygen provider/respiratory therapist recommendation
○ Continuous: ○ compressed gas tank + O_2 concentrator
○ Portable: ○ home-filled tank + O_2 concentrator ○ liquid oxygen system ○ portable concentrator
○ Nocturnal only (concentrator)

Anticipated duration of need:

○ 90 days *OR* ○ Other: _____days _____month(s) _____a year or longer

Initial O_2 prescription is authorized for 90 days. Need for continued oxygen therapy must be validated at these intervals to continue coverage:

- Within 60-90 days of initiation of therapy
- Annually thereafter

Ordering Physician Signature: _____

Healthcare Provider: Fax or send this form directly to the oxygen provider at the time of prescription.

Oxygen provider name: _____ Phone: _____ Fax: _____

Oxygen Provider:

1. Verify oxygen setup below and fax or send to SelectHealth for verification of oxygen benefit and payment.
2. Also fax a copy to ordering physician's office for verification of oxygen set-up (see physician FAX number at top of form).

Date of setup: _____ Flow rate: _____L/min O_2 SAT after setup: _____

Delivery system: _____

For more information or additional copies of this form, go to the intermountainphysician.org/clinicalprograms.

Order 50261