Quick*Start* Physician Order Form

Oxygen Therapy System For All Home, Portable, And Travel Needs.

Simply fax the following information and we will handle all the details.

PATIENT INFORMATION:

Name: ______________________ New O2 Patient ☐ Yes ☐ No

City: ____________ State: ______ Zip: ____________ Phone: ______________

Male/Female: __________ Date-of-Birth: __________ SS# ______________

Primary Insurance: ☐ Medicare # ______________ ☐ PPO/HMO #: ______________

OXYGEN ORDER AND LABORATORY INFORMATION:

☐ Oxygen Therapy System For <u>All</u> Home, Portable, And Travel Needs.

1. Length of need: __________ (99 = lifetime)
2. O2 Order: ☐ Nocturnal ☐ While Active ☐ 24 Hours Daily
3. Are Your Ordering Portable Oxygen: ☐ Yes ☐ No
4. Highest O2 Flow Rate Prescribed (Liters Per Minute) ____________
5. Qualifying Diagnosis: ☐ COPD ☐ Chronic Bronchitis ☐ Emphysema ☐ CHF ☐ Other __________
6. Qualifying SAT%: ________ Test Date: __________ ☐ At Rest ☐ During Exercise ☐ During Sleep

PHYSICIAN INFORMATION:

Doctor Name: ______________________ NPI#: __________ Date: ____________

City: ______________ State: __________ Zip: ______________

Phone: ______________________ Fax: ______________________

Physician Signature: ______________________ Sent By: ______________

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