



(718) 418-2000 / FAX: (718) 326-1400

Order Date: ___/___/___

Delivery Date: ___/___/___

RESPIRATORY EQUIPMENT

Patient Name _____

Patient's Address _____

Patient's Phone # _____

Diagnosis _____

Height _____ Weight _____

Date of Birth [] M [] F

Primary Insurance _____
 Identification Number _____
 Phone Number _____

Secondary Insurance _____
 Identification Number _____
 Phone Number _____

Emergency Contact Information
 Name _____
 Phone _____

Referral Contact Information
 Ref. Name _____
 Ref. Phone _____

Special Delivery Information:

Saturation _____ % or PO₂ _____

[] at Rest [] exercise with O₂

[] exercise without O₂

Test Date: _____

Oxygen Therapy

- Oxygen Concentrator
- Portable Concentrator
- Liters per minute _____
- Hours per day _____
- Over Night Pulse Oximetry Test
- Home Fill Units
- Oxygen Conserving Device
- Other _____

Sleep Equipment

- CPAP _____ Cm H₂O
- Auto CPAP min. _____ max. _____ CmH₂O
- BiPap _____ Ipap _____ Epap _____

Nebulizers

- Nebulizer with Compressor and Non-Disposable Neb Kit
- Other _____

Diagnosis

- COPD [] Other
- CHF _____
- Asthma _____
- Emphysema _____
- Sleep Apnea
- Complex and Central Sleep Apnea

Physician Name _____	_____
Physician Address _____	NPI # _____
Physician Phone # _____	License # _____
Physician Signature _____	Date / / _____