DIAMOND

Questions? (800) 977-3002

DETAILED WRITTEN ORDER - RESPIRATORY

Order Date

Doctor's Name

NPI #

Patient's Name

FAX THIS FORM TO:
(800) 438-2048

OXYGEN:

Please send pulse oximetry or ABG results with this form. Qualifying results are Po2 <=55 (ABG) -OR- pulse ox of 88% or below.

☐ **Stationary Oxygen Concentrator** (E1390)

☐ **Portable Gaseous Tank** (E0431)

☐ **Conserving Device**

@ _____ Liter Flow (LPM)

To be used:

☐ **Continuously**

☐ **While ambulating** _____ Hours per day

☐ **Nocturnally**

Via

☐ **Nasal Cannula** ☐ **Mask**

☐ **Trachea Collar** ☐ **Bleed into PAP therapy**

Other Orders

CPAP / BiLEVEL / BiLEVEL ST:

Please send baseline sleep study, titration and office notes (dated prior to **baseline** sleep study) with this form.

☐ **CPAP** (E0601) ☐ **Auto CPAP** (E0601)

Pressure or range: _____ cm H2O

BiLevel (Also known as BiPAP or RAD)

☐ **RAD w/o back up rate** (E0470) I/E _____ cm H2O

☐ **RAD with back up rate** (E0471) I/E _____ cm H2O + B/U Rate

☐ **Heated Humidifier** (E0562)

Accessories: Replace according to the following schedule

☐ **Full Face Mask** (A7030) 1/3mo ☐ **Nasal Mask** (A7034) 1/3mo
☐ **Face Mask Cushion** (A7031) 1/mo ☐ **Nasal Cushions** (A7032) 2/mo
☐ **Disposable Filters** (A7038) 2/mo ☐ **Nasal Pillows** (A7033) 2/mo
☐ **Heated Tubing** (A4604) 1/3mo ☐ **Std Tubing** (A7037) 1/3mo
☐ **Headgear** (A7035) 1/6mo

** Unless brand and size are specified the best fitting mask will be provided to patient.

Specific Instructions

NON-INVASIVE VENTILATION

Please complete the following **only** for patients with Chronic Respiratory Failure secondary to COPD, restrictive thoracic disorder, Obesity Hypoventilation Syndrome or neuromuscular disorders.

☐ **Trilogy Evo** (E0465 or E0466) ☐ **Astral** (E0465 or E0466)

☐ **AVAPS AE or IVAPS 6-8ml/kg Vt via mask continuous**

☐ **PS w/Vt - PS 5, PEEP 5, RR 10, Vt500 continuous** (Astral Only)

☐ **Daytime mode: Mouth piece ventilation with AC or PAC(V) 800cc x, Ti 1.5 (adjust to comfort), square wave**

Other settings: _____

NEBULIZER:

☐ **Nebulizer Machine** (E0570)

☐ **Non disposable neb circuit** (A7005) **Refill 1/6 mo.**

☐ **Disposable neb circuit** (A7003) **Refill 2 per mo.**

☐ **Aerosol mask** (A7003) **Refill 1/6 mo.**

Medication (name, concentration, dose, frequency):

I Certify that a face to face evaluation was performed within 6 months of the date of this prescription.

Dr. Signature

Date of Signature

For Office Use

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