Respiratory Order Form

Name: ___________________________ **Agency:** ______________________________
DOB: _____/ _______/ ___________ **Fax:** ___________________________________
MRN: _____________________________ **Duration of Need:** _________Months (max 12 months)
Demographics and supporting clinical documentation needs to be faxed with order

Primary Care Provider if not the ordering Provider: _____________________________

- ☐ **Suction Machine** with Canisters, tubing, filters
  - ☐ Portable ☐ Stationary
  - ☐ Suction Catheters _____Fr Disp: 10 per month
  - ☐ Little Suckers/Nasal Aspirators Disp: 2 per month
  - ☐ Younker Disp: 1 per month

In additional to Diagnosis to below: Sialorrhea 527.7

☐ **Nebulizer** ☐ **Supplies only**
☐ Medication Cup with tubing ☐ Mask
Disp: Max allowable / mo prn
Diagnosis: ___Asthma 493.90 __Wheezing 786.07 ___Cough 786.2

☐ **Spacer** ☐ **Spacer with Mask** Size: ☐ Small ☐ Medium ☐ Large
Disp: 1
Diagnosis: ___Asthma 493.90 __Wheezing 786.07 ___Cough 786.2

☐ **Pulse Oximeter**
Low Oxygen Saturation Alarm: _____ % High Heart Rate Alarm: _______ Low Heart Rate Alarm: _________

☐ **Oxygen**
Via: ☐ NC ☐ Mask ☐ Trach
Liter Flow Minimal: _____L/min Max: ______L/min
☐ Intermittent ☐ Contnuous
Last Room Air O2 Sat: _______ Date: _________________

__CEREBRAL PALSEY 343.9
__ENCEPHALOPATHY 348.3
__CHRONIC RESPIRATORY INSUFFIENCY 786.09
__CHROMOSOMAL DISORDER 758.9
__ARTHROGRYPOSIS 728.30
__ANOXIC BRAIN INJURY 348.1
__CLD 770.7
__CHF 728.0
__HYPOXIA 799.02
__SEIZURE DISORDER 345.9
__OTHER: _____________________
____

Physician Signature: _______________________________________ Date: ______/ _____/ ________
Physician Printed Name: __________________________________ NPI: _______________________
Address: _________________________________ City: _________________________ State: _____ Zip ______________
Phone: _____/ ______ - ____________ Fax: _____/ ______ - ____________