2594 N Fordham Ave, Fresno, CA 93727
Phone (559)-252-0100
Fax (559)-252-0400

Patient Name: ________________________________ **Date of Birth** ______________ **Phone #** ________________ **Patient Height:** ____________

Address: ____________________________________ **City** ___________ **State** ________ **Zip**____________ **Patient Weight:**____________

Setup as: Urgent ☐ **Next Day** ☐ **Within 1 week** ☐ ***Please, don't forget to Fax the Insurance Information on new orders, thank you!***

HOME OXYGEN	☐**Overnight Oximetry** ☐HOME OXYGEN @ ___ LPM (VIA TUBING AND CANNULA) ☐ CONTINUOUS (24 HRS) ☐ NOCTURNAL (8-10HRS) ☐ PORTABLE OXYGEN W/CONSERVING DEVICE @_______LPM ☐ O_2 HUMIDIFIER ☐ OXYGEN TEST _______% PO2 ______MMHG. DATE_______________ LOCATION_______________ **DIAGNOSIS** ☐ CHF (428.0), ☐COPD (496), ☐ EMPHYSEMA (492.8), ☐ CHRONIC BRONCHITIS (491.8), ☐ ASTHMA (493.91),☐ LUNG CA (197.0), ☐CORPULMONALE (415.0), ☐ CYSTIC FIBROSIS (277.00), ☐OTHER ____
VENTILATION	☐ RESPIRONICS TRILOGY ☐ RESMED ASTRAL 150 ☐ OTHER___________________________________ **DIAGNOSIS** ☐ RESPIRATORY FAILURE , ________________________
AIRWAY CLEARANCE DEV	☐ AFFLOWVEST ☐ COUGH ASSIST ☐ OTHER_____________________________________ **DIAGNOSIS** ☐ _________________________
CPAP/BI-PAP	☐ **SLEEP STUDY** ☐ CPAP, ☐ BI-PAP, ☐ PRESSURE ____CM H2O, ☐ IPAP______/EPAP_____ ☐ NASAL ☐ FULL FACE MASK_________ ☐MASK SIZE_____ ☐HEADGEAR ☐CHIN STRAP☐ TUBING☐ HEATED HUMIDIFIER ☐FILTERS (NON DISPOSABLE)☐FILTERS (DISPOSABLE) **DIAGNOSIS** ☐OSA (327.23), ☐OBESITY (278.00), ☐HYPERSOMNIA WITH SLEEP APNEA (780.53),☐______________________
ORTHOPEDIC BRACING	☐ BACK BRACE,☐ KNEE BRACE LT / RT ☐ANKLE BRACE LT / RT☐WRIST BRACE LT / R **DIAGNOSIS**:☐ OA (715.9), ☐ OA OF KNEE (719.16) ☐ LOW BACK PAIN (724.2), ☐KNEE PAIN (719.46)☐ SPINAL STENOSIS (724.02), ☐ RHEUMATOID ARTHRITIS (714.0) , ☐ IMPOTENCE (607.84)☐ OTHER___________________________________
DURABLE MEDICAL EQUIPMENT	☐PT EVALUATION FOR PMD ☐POWER WHEELCHAIR☐POWER SCOOTER ☐ REPAIRS ☐ LABOR FOR REPAIRS☐ REPLACEMENT BATTERIES ☐ MANUAL WHEELCHAIR -- ☐*STANDARD*☐*LIGHTWEIGHT*☐TRANSPORT CHAIR ☐ *ELEVATING LEG REST LT / RT* ☐*W/C (GEL / BASIC) CUSHION* ☐ *BACK CUSHION*☐ *REAR ANTI-TIPPER(X 2)*☐*BRAKE EXTENSIONS (X2)* ☐HOSPITAL BED (SEMI-ELECTRIC W/MATT)☐TRAPEZES☐ GEL MATTRESS OVERLAYS **DIAGNOSIS :** ☐ABNORMALITY OF GAIT (781.2), ☐DJD (715), ☐ RHEUMATOID ARTHRITIS, (714.0) ☐OSTEOARTHROSIS (715.10), ☐ OSTEOPOROSIS(733.00), ☐PAIN IN JOINT (719.40), ☐MUSCULAR DYSTROPHY (359) ☐ MS (340), ☐ QUADRIPLEGIA(344), ☐Cerebral Palsy (343.9), ☐ HEMIPLEGIA (342.00), ☐ CHF (428.0), ☐COPD (496), ☐ EMPHYSEMA (492.8), ☐ CHRONIC BRONCHITIS (491.8), ☐ CVA (436) ☐ HYPERLIPIDEMIA (272.4)☐ DIABETIC (250.00) ☐ CAD (414.9) ☐DEMENTIA (290) OTHER DX NOT LISTED ☐____
LENGTH OF NEED	☐LIFE TIME ☐OTHER _________________ FOR SERVICE BEGINNING DATE_____________________
MD INFO	PHYSICIAN'S NAME________________________ PHONE__________________________ FAX___________________________ **ADDRESS:-**______________________________ **CITY:**________________________ **ZIP:**______________ STATE LICENSE __________ UPIN:# ___________NPI___________________________ **PHYSICIAN'S SIGNATURE**____**DATE**______________________

This form is to serve as an order placed with Respiratory Care Plus to provide home medical equipment and services for the patient named above. Please verify the products and/or services you are requesting by placing an (X) in the applicable area, and then fax the form to complete your order. If we may be of assistance to you in placing your order, please call (559) 252-0100. Please fax this completed form to (559) 252-0400. We will contact your staff promptly to verify receipt of this order and to obtain any other necessary information needed to complete delivery.