ROTECH

2545 PERRYTON PKWY STE 2B PAMPA, TX 79065
P: 806-665-5571 option 1 F: 806-665-8986

ORDER FORM

RBL 7/16/20

Name: Joseph [illegible] Klein DOB: 2-11-61 Gender: [X] Male [ ] Female Date: 7-16-20

Address: _____ City: _____ St: _____ Zip: _____ Phone: _____

Estimated LON: 99 Months (lifetime) **OR** _____ Face-to-Face Needs Assessment Date: _____ Height: _____ Weight: _____

Diagnosis:

- [ ] ALS (G12.21)
- [ ] Asthma, Extrinsic (J45.20)
- [ ] Asthma (J45._____)
- [ ] Central Sleep Apnea (G47.31)
- [ ] CHF (I50.9)
- [ ] Chronic Bronchitis (J41.0)
- [X] COPD (J44.9)
- [ ] CVA (I63.50)
- [ ] Emphysema (J43.9)
- [ ] Hypoventilation Syndrome (G47.35)
- [ ] Hypoxemia (R09.02)
- [ ] Lung Cancer (C34.90)
- [ ] OSA (G47.33)
- [ ] Pulmonary Fibrosis (J84.10)
- [ ] Resp Failure, Unspecified (J96.00)
- Other: _____
- Other: _____
- Other: _____
- Other: _____
- Other: _____

RESPIRATORY EQUIPMENT

- [ ] O_2 Concentrator (E1390) **OR** _____
- [ ] O_2 Portable Gaseous System (E0431) (incl oxygen contents) **OR**: _____

Dosing Instructions:

_____ LPM via Nasal Cannula **OR** [ ] Mask **OR** [ ] PAP Device **OR** Invasive Vent
Continuous **OR** [ ] Exercise/Exertion **OR** [ ] Hours of Sleep Only
[ ] Conserving Device

[ ] Nebulizer Compressor (E0570)w/ disp filter (2 per 1 mo) and reusable filter (1 per 3 mos) (if app) & w/disp admin set (2 per 1 month) + neb set (2 per 1 mo) **OR** w/[ ] Mask (1 per 1 mo) + Neb Set (2 per 1 mo); **OR** w/[ ] Reusable Admin Set (1 per 6 mos). Medication Used in Nebulizer: _____

SLEEP THERAPY

[ ] CPAP w/Modem (E0601):		_____ cmH_2O				*Ramp set to patient comfort on any PAP device unless otherwise ordered:* _____	
[ ] Auto CPAP w/Modem (E0601):	Min:	_____ cmH_2O	Max:	_____ cmH_2O			
[ ] BiPAP w/Modem (E0470):	IPAP:	_____ cmH_2O	EPAP:	_____ cmH_2O			
[ ] Auto BiPAP w/Modem (E0470):	Max Press:	_____ cmH_2O	Max IPAP:	_____ cmH_2O	Max EPAP:	_____ cmH_2O	
[ ] RAD w/Backup & Modem (E0471):	IPAP:	_____ cmH_2O	EPAP:	_____ cmH_2O	Backup Rate:	_____	
[ ] ASV w/Modem (E0471):	Max Press:	_____ cmH_2O	Min EPAP:	_____ cmH_2O	Max EPAP:	_____ cmH_2O	
	PS Min:	_____ cmH_2O	PS Max:	_____ cmH_2O	Backup Rate:	_____	

Mask Interface: ***(choose only 1 interface – substitution permitted)***

- [ ] Nasal Mask (1 per 3 months) (A7034) & Nasal Mask Cushion (2 per month) (A7032)
- [ ] Nasal Pillow Mask (1 per 3 months) (A7034) & Nasal Pillow Cushion (2 pair per month) (A7033)
- [ ] Full Face Mask (1 per 3 months) (A7030) & Full Face Mask Cushion (1 per month) (A7031)
- [ ] Oral Mask Interface (1 per 3 months) (A7044) & Oral Mask Cushion (2 per month) (A7028)
- [ ] Combo Oral/Nasal Mask Interface (1 per 3 months) (A7027) with Oral Cushion (2 per month) (A7028) & Nasal Pillows (2 per month) (A7029)

Accessories:

- [ ] Heated Humidifier (E0562)
- [ ] Humidifier (Passover) (E0561)
- [ ] Humidifier Chamber (1 per 6 months) (A7046)
- [ ] Standard Tubing (1 per 3 months) (A7037)
- [ ] Heated Tubing (1 per 3 months) (A4604)
- [ ] Headgear (1 per 6 months) (A7035)
- [ ] Chinstrap (1 per 6 months) (A7036)
- [ ] Filter: Disposable (2 per month) (A7038)
- [ ] Filter: Non-disposable (1 per 6 months) (A7039)

DIAGNOSTIC

- [X] Overnight Oximetry on Room Air **OR** dNO2 for PAP with Capnography
- [ ] Sleep Screening w/AHI
- [ ] Other: _____

WHEELCHAIR & ACCESSORIES

- [ ] Standard (K0001)
- [ ] Lightweight (K0003)*
- [ ] Heavy Duty (K0006)*
- [ ] Extra Heavy-Duty (K0007)*

unable to self-propel in standard wheelchair

- [ ] General Use Seat Cushion (E2601) & Back Cushion (E2611) ≤22"wide
- [ ] General Use Seat Cushion (E2602) & Back Cushion (E2612) >22"wide
- [ ] Elevating Leg Rests (pair) (K0195)
- [ ] Heel Loops (E0951) (x2 for pair)
- [ ] Wheel Lock Extensions (E0961) (x2 for pair)
- [ ] Anti-tippers (E0971) (x2 for pair)
- [ ] Safety Belt (E0978)

HOSPITAL BED & ACCESSORIES

- [ ] Semi-Electric[1](E0261) w/Therapeutic Foam Mattress (E0184)

Other: _____

- [ ] Trapeze (free standing) (E0940)
- [ ] Trapeze (bed attached) (E0910)
- [ ] Patient Lift (E0630)

[1]*In addition to meeting fixed height bed criteria, patient's medical record must document condition requires frequent and/or immediate changes in body position.*

AMBULATORY AIDS

- [ ] Walker (Folding) (E0135)
- [ ] Walker (Folding w/ Wheels) (E0143)
- [ ] Walker (w/Wheels + Seat) (E0143 +E0156)
- [ ] Walker (Heavy Duty w/Brakes)[2] (E0147)
- [ ] Walker (Heavy Duty) (E0148)
- [ ] Bedside Commode (E0163)
- [ ] Crutches (alum or non-wood) (pair) (E0114)
- [ ] Cane (E0100)
- [ ] Quad Cane (E0105)

[2]*Must have a second qualifying diagnosis other than obesity*

OTHER EQUIPMENT: _____

ATTACH THE FOLLOWING (AS APPLICABLE)

- [ ] Test Results (Oximetry, ABG, Sleep Study)
- [ ] Patient Demographics Sheet and Insurance Card
- [ ] Physician's Notes *(from medical record documenting face-to-face needs assessment and expected benefit from equipment ordered above; physician must sign and date notes)*

PRESCRIBED BY INFORMATION

Name: Dr. Ralf Jueknes NPI: 1053607507 Phone: 329-3050 Fax: 419-1052

Address: 2545 Perryton Pkwy Ste 2B City: Pampa State: TX Zip: 79065

Prescribed By Signature: [signature] Date: 7/16/20