



FAX COVER SHEET

Attention:

Date:

Patient:

From:

DOB:

Patient ID#:

Phone:

Sender's Phone Number: **(484) 567-0666**

Fax:

Sender's Fax Number: **(484) 362-1480**

IMPORTANT!

We require the results of an Overnight Sleep Study, either from a recent appointment or from any year.

This patient is due for a 5-year Oxygen Replacement. The patient's insurance requires that we verify the patient is continuing to use and benefit from oxygen therapy.

Oxygen Determination Testing (within 30 days of a Physician Evaluation)

Continuous Oxygen Test (6-minute walk test or ABG test)

- at rest on room air (if Spo2 is 88% or less then no further testing needed)
- during exertion on room air (spo2 must be 88% or less; must complete 3rd test)
- during exertion with oxygen applied (must show oxygen level increases w/ O2 use)

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