Valley Home Medical (137510)
6973 S. 300 w.
Midavle, UT 84047
ATTN: Paul Lopez
PHONE: (801) 563-0202 **FAX: (801) 563-5188**

PHYSICIAN FAX ORDER

PATIENT INFORMATION

Name:			Date:	
Address:		City:	State:	Zip:
Phone:	SSN:	DOB:	Height:	Weight:

Diagnosis:
☐Chronic Bronchitis (491.20) ☐Emphysema (492.8) ☐OSA (327.23) ☐Other: _____
☐COPD(496) ☐Extrinsic Asthma (493.00) ☐Unspecified Asthma (493.90)

Length of Need: Months (99=lifetime)	Drug Allergies:

INSURANCE INFORMATION

Primary Insurance Carrier:	Group Number:	Policy Number:	Phone:
Secondary Insurance Carrier:	Group Number:	Policy Number:	Phone:

RESPIRATORY EQUIPMENT

Oxygen

☐Oxygen LPM: ____ Hrs/Day: ____ ☐Continuous ☐Nocturnal ☐Nasal Cannula ☐Mask
Room Air Sat: ____ ☐Rest ☐Exercise ☐Sleep (must be 5 mins)
Test Date: _____
Test Facility: _____
☐Portable LPM: ____ ☐Conserving Device @ _____
Address: _____

Positive Airway Pressure Device

☐CPAP Pressure: ____ cmH_2O Ramp: ____
☐Auto-Titrating CPAP Min: ____ Max: ____
☐BIPAP IPAP: ____ EPAP: ____ Rate: ____

☐Mask ☐Nasal Pillows ☐Full Face Mask
☐Mask Cushion ☐Headgear ☐Tubing
☐Filters (disposable) ☐Filters (reusable)
☐Humidifier ☐Humidifier (heated) ☐Humidifier Chamber

Diagnostic Testing

☐Overnight Oximetry on room air by IDTF ☐Overnight Oximetry on room air (non-IDTF)
☐Home Sleep Test (HST): ☐If HST is positive for obstructive sleep apnea, setup auto-titrating CPAP with Min Pressure:____ Max Pressure:____
☐Sleep Screening (AHI screening)

NEBULIZER MEDICATIONS *(provided by Pulmo-Dose)*

Medications	To Be Administered Via Nebulizer/Compressor

Length of Need (nebulizer medications): 12 months or ☐ Other: (dispense as one month supply)
Dispense with one reusable nebulizer kit (A7005) every 6 months or as written:

DURABLE MEDICAL EQUIPMENT

☐Bedside Commode ☐Walker ☐Wheelchair (Heavy Duty) ☐Wheelchair Cushion
☐Hospital Bed ☐Wheelchair (Lightweight) ☐Elevating Leg Rest ☐Other
☐Nebulizer (includes one reusable nebulizer kit (A7005) Replace neb kit once every six months

PHYSICIAN INFORMATION

Physician's Name:		NPI:		State License:	DEA#:
Address:	City:	State:	Zip:	Phone:	Fax:
Physician Signature:					Date: