CNS Respiratory	**Respiratory Prescription Referral Form**
3685 West 6200 South Taylorsville, Utah, 84129 Phone: (801) 973-0900 Fax: (801) 708-7866	CNS Respiratory Services CNS Cares

Date:	**Ordering Contact:**	**Phone #:**	**Fax #:**

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**	
Address 1:	**Apt. #:**	**City/State/Zip:**	
Alternate Contact/Relationship:		**Alt. Phone #:**	
Primary Insurance Plan:	**Ins. ID#:**		**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**		**Group #:**
Subscriber Name/Relationship:			**Subs. DOB:**
Following Phys. (if diff. than Ordering):		**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Length of Need: _____ Months (99 = Lifetime)

Oxygen Saturations for Home Oxygen System (Stationary and/or Portable)

➡ **Required:** Prescribed Oxygen Frequency @ ____ lpm*

____**% at rest on Room Air**	*(≤ 88% on room air at rest?)*	➡ ☐ Continuous via Nasal Cannula
____**% activity on Room Air**	*(> 88% on room air at rest; ≤ 88% on room air w/activity?)*	➡ ☐ w/ Activity via Nasal Cannula
____**% activity on O2 @ ___ lpm***	*(*if ≥ 4 lpm, most recent sats on O2 @ 4 lpm: ____ %)*	**Testing Date:** _____

(≤ 88% for > 5 mins. sleep or decrease of 5% from baseline?) ➡ ☐ Nocturnal via ☐ Nasal Cannula *or* ☐ Bleed-in w/ PAP

Testing Location: _____ **Testing Date:** _____

Testing Performed: ☐ Within 30 days prior to order (outpatient) *or* ☐ Within 2 days of discharge from inpatient admission (hospital, SNF)

☐ **Overnight Oximetry** performed on ☐ Room Air *or* ☐ Oxygen @ _____ lpm *and/or* ☐ PAP System

ICD 10 Codes

☐ J44.9 – COPD
☐ I27.23 – Pulmonary Hypertension
☐ C34.90 – Lung Cancer
☐ J43.9 – Emphysema
☐ Other_____
☐ R09.02 - Hypoxia
☐ J96.00 – Acute Respiratory Failure
☐ J45.909 – Unspecified Asthma, Uncomplicated
☐ I26.99 – Pulmonary Embolism

Comments:

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN SIGNATURE AND DATE]

Physician Printed Name: **NPI#:**

➡ **Physician Signature: X** ➡ **Date:**

Please attach supporting documentation & fax to (801) 708-7866

THANK YOU FOR CHOOSING CNS RESPIRATORY SERVICES