ARROW RESPIRATORY CARE

Arrow Respiratory Care
9567 Arrow Rte., Ste. L
Rancho Cucamonga, CA 91730
Phone: 909-987-1661
FAX: 909-363-7333
Email: arrowcares@yahoo.com

Physicians Written Order

******REQUIRED: Initial Date: _____ ****** **NPI#_____**

PATIENT INFORMATION

Last, First M _____ Phone _____

Other Phone _____ Emergency Contact _____ Phone _____

Email _____ Date of Birth _____ Gender ☐ M ☐ F Height _____ Weight _____

PHYSICIAN INFORMATION

Practice Name _____ Physician First, Last _____

Address _____ Contact Name _____

City _____ State____ Zip_____ Email _____

Office Phone_____ Office Fax _____

SLEEP THERAPY *Length of Need (months) 99 =Lifetime unless otherwise specified*_____

- ☐ **CPAP** (E0601) _____cmH20
- ☐ **Auto CPAP** (E0601) min_____/max_____ cmH20
- ☐ **Bi-Level** (E0470) IPAP_____/EPAP_____cmH20
- ☐ **Auto Bi-Level** (E0470) IPAP max_____/EPAP min_____cmH20 PS max _____cmH20
- ☐ **Bi-Level ST** (E0471) IPAP_____/EPAP_____cmH20 Rate _____BPM
- ☐ **ASV** (E0471) EPAP min_____/max _____cmH20 PS min _____/PS max _____cmH20
  Max Pressure _____cmH20 Rate _____BPM

SLEEP THERAPY INTERFACE (* *Indicates standard supplies needed per mask type)*

NASAL MASK
- ☐ Nasal Mask (A7034) *1 per 3 mo**
- ☐ Seals/Cushions (A7032) *1 per mo*
- ☐ Headgear (A7035) *1 per 6 mo**
- ☐ Tubing (A7037) *1 per 3 mo**
- ☐ Disposable Filter (A7038) *2 per mo**
- ☐ Reusable filter (A7039) *1 per 3 mo**
- ☐ Water Chamber (A7046) *1* per 6 mo*
- ☐ Heated Humidification (E0562)*

FULL FACE MASK
- ☐ Full Face Mask (A7030) 1 *per 3 mo **
- ☐ Seals/Cushions/Flaps (A7031) *1 per mo*
- ☐ Headgear (A7035) - *1 per 6 mo**
- ☐ Tubing (A7037) *1 per 3 mo**
- ☐ Disposable Filter (A7038) *2 per mo**
- ☐ Reusable filter (A7039) *1 per 3 mo**
- ☐ Water Chamber (A7046) *1* per 6 mo*
- ☐ Heated Humidification (E0562)*

NASAL PILLOWS
- ☐ Nasal Pillows (A7033) *2 per mo**
- ☐ Headgear (A7035) - *1 per 6 mo**
- ☐ Tubing (A7037) *1 per 3 mo**
- ☐ Disposable Filter (A7038) *2 per mo**
- ☐ Reusable filter (A7039) *1 per 3 mo**
- ☐ Water Chamber (A7046) *1* per 6 mo*
- ☐ Heated Humidification (E0562)*

OTHER
- ☐ Chin Strap (A7036) *1 per 6 mo*
- ☐ Heated Wire Tubing (A4064) *1 per 3 mo**

DIAGNOSIS ☐ OSA (327.23) ☐ Complex / Central Sleep Apnea (327.21) ☐ Other _____

HOME OXYGEN *Length of Need (months) 99 =Lifetime unless otherwise specified*_____

☐ Oxygen @ _____ LPM ☐ Continuous ☐ Nocturnal ☐ Ambulating **DELIVERY METHOD** ☐ Nasal Cannula ☐ Other_____

TEST RESULTS (Required) Test Date_____ RA SAT_____%

AMBULATING ONLY SpO2% RA Resting _____ RA Ambulating_____ Ambulating on O2_____ LPM

DIAGNOSIS ☐ COPD (496) ☐ Emphysema (491.21) ☐ Chronic Bronchitis (491.0) ☐ Chronic Asthma (493.20) ☐ Other _____

AEROSOL THERAPY *Length of Need (months) 99 =Lifetime unless otherwise specified*_____

☐ Nebulizer Compressor and Kit (E0570, A7003) **SUPPLIES** ☐ Nebulizer Kit (A7003) *2 per mo* ☐ Mask (A7015) *1 per mo* ☐ Meds _____

DIAGNOSIS ☐ COPD (496) ☐ Emphysema (491.21) ☐ Chronic Bronchitis (491.0) ☐ Chronic Asthma (493.20) ☐ Other _____

OXIMETRY TESTING ☐ Overnight **Select One** ☐ Room Air ☐ with PAP @ _____cmH20 ☐ with 02_____LPM

DIAGNOSIS ☐ COPD (496) ☐ Emphysema (491.21) ☐ Chronic Bronchitis (491.0) ☐ Chronic Asthma (493.20) ☐ Other _____

I, the undersigned, certify that the above prescribed equipment/supplies are medically necessary with reference to accepted standards of medical practice of the patient's condition.

_____ _____

Physician/Provider Signature **Date**

Fax to: 909-363-7333 **Or email: arrowcares@yahoo.com**