California Home Medical Equipment
Oxygen, PAP/RAD, Nebulizer and Suction Prescription Form
Fax to (650) 931-8928 or Call (650) 357-8550
Website: www.chme.org / Email: orders@chme.org

Patient Information (Patient name and attach demographic info)

Patient's Name:_____ Address: _____
Date of Birth: _____ City: _____
Patient's Phone: _____ State: _____ Zip: _____
Height: _____ Weight: _____

Requested Documents (as pertained)

☐ Insurance ☐ O2 Saturation Rates / ABG ☐ Medication List ☐ Sleep Study ☐ Progress Notes

***California Home Medical Equipment will verify insurance eligibility and obtain authorization.**

Diagnosis

☐ COPD – J44.9 ☐ Chronic Bronchitis – J42 ☐ Emphysema – J43.9 ☐ PNA – J18.9 ☐ CHF – I50.9
☐ Pulmonary Fibrosis – J84.10 ☐ OSA G47.33 ☐ Central Sleep Apnea – G47.31 ☐ Dysphagia R13.10
☐ Other _____ **Length of Need**: _____

OXYGEN

Oxygen Prescribed @_____LPM Hours Per day:_____☐ Nocturnal ☐ Continuous ☐ Exertion
Device: ☐ Nasal Cannula ☐ O2 mask ☐ Oxymizer – Cannula / Pendant (Circle One)
☐ Other _____
Oxygen System: ☐ Oxygen Concentrator, Home-fill System with Portable Tank
Test Results: RA @ Rest SaO2_____ Date of Test_____
Ambulatory oxygen only: **1.** RA @ Rest O2 Sat _____**%**
2. RA O2 Sat w/exertion _____**%**
3. O2 Sat on _____ l/m of oxygen w/exertion _____**%**
☐ **RT to evaluate patient and determine OCD (O2 Conserving Device) system – Titrate SpO2 ≥** _____**%**
*Patient must pass OCD test: ☐ POC (Portable Oxygen Concentrator – pulse setting only)
☐ **Nocturnal Oximetry –** ☐ Room Air ☐ CPAP/BiPAP Settings _____ ☐ Oxygen _____ LPM

PAP/RAD

☐ **CPAP/Auto CPAP** **Settings:** _____cm H20
☐ **BiPAP/Auto BiPAP** **Settings:** IPAP: _____cm H20 / EPAP: _____cm H20 ☐ **O2 Bleed-In:** _____ LPM
Pressure Support: Min: / Max: _____ Back-Up Rate: _____Ramp time if specified: _____
Supplies: ☐ Heated Humidifier ☐ Filters & Cushions ☐ Standard Tubing ☐ Heated Tubing
☐ Mask Type _____

NEB / SUCTION

☐ **Nebulizer (SVN)** Tx Frequency: ☐ qid ☐ tid ☐ bid sig: _____
Medications: _____ **Refills:** ☐ 12 months ☐ other _____
_____
**CHME does not provide medication. Listed medication is strictly used for determination of coverage of benefits by insurance.*
☐ **Nebulizer (LVN)** ☐ Corrugated Tubing 100' ☐ Trach Mask ☐ Drainage Bag ☐ Neb Bottle
☐ **Stationary Suction** ☐ **Portable Suction** ☐ Yankauers ☐ Catheters _____(Size)

Physician Name: _____ Contact: _____
Address: _____ Phone: _____
NPI #: _____

Physician Signature: _____ Date: _____