**Oxygen System and Supplies***

**Prescription:**
- Setting: _____lpm or _____%
- Duration: [ ] Continuous [ ] Other
- Device: [ ] NC [ ] Trach Collar [ ] Other: _______
- Initiate Conserving Device for portable use
- Standard Setting 1-5 Keep SaO2 above______%

**Qualifications:** Location of Test:_______ Date of Test__/__/__

[ ] TEST TAKEN AT REST:
- Saturation: _____% or PaO2____ on [ ] Room Air or [ ] _____lpm

[ ] TEST TAKEN DURING EXERCISE/AMBULATION:
(All below must be completed within same time frame)
- SaO2 at rest without O2_____ %
- SaO2 during exercise without O2_____%
- S02 during exercise with O2_____%

**Supplies**: delivery device, Tubing, portable tanks, regulators

- **Wheelchair**
  - **Prescription:** [ ] Standard [ ] Lightweight [ ] Heavy Duty
  - **Supplies/Accessories:** [ ] Elevating Legrests [ ] seatbelt
  - [ ] armrest [ ] anti-tippers

- **Hospital Bed**
  - **Prescription:** [ ] Semi-Electric OR [ ] Full-Electric *
  - **Supplies/Accessories:** [ ] Full Rails OR [ ] Half Rails
  - [ ] Trapeze Bar : [ ] Fixed OR [ ] Floorstand
  - [ ] Hoyer Lift w/ standard sling

- **Ambulatory Aids**
  - **Prescription:** (only one below can be provided)
  - [ ] Cane: [ ] Straight OR [ ] Quad
  - [ ] Crutches: [ ] Standard OR [ ] Forearm
  - [ ] Walker: [ ] Adult OR [ ] Youth OR [ ] with seat
  - [ ] Walker Wheels: [ ] 5” OR [ ] 3”

- **Bath Aids**
  - **Prescription:**
  - [ ] Commode: [ ] Standard OR [ ] Drop Arm
  - [ ] Shower Chair: [ ] Standard OR [ ] With Back
  - [ ] Transfer bench

- **Suction Machine and Supplies**
  - **Prescription:** [ ] Oral OR [ ] Tracheal/Oral
  - [ ] Suction Catheters
  - Size: ________Fr Quantity: ________/Month

  * if ordered for >300 per month, medical justification needed

  **Supplies/Accessories:** Jar, Tubing, Yankauer

- **Nebulizer and Supplies**
  - **Prescription:** [ ] Stationary OR [ ] Portable**
  - **Supplies:** Nebulizer kits, Masks

  **may not be covered

This form must be signed and dated by the prescribing physician before the therapy/equipment may be considered for payment.

Physician’s signature certified that the above represents his judgment of the patient’s need for the therapy/equipment.