



411 Main Street, Mapleton, IA 51034 • 712-881-1033

# VERBAL ORDER FORM

## Oxygen ♦ DME ♦ Prescriptions ♦ CPAP/Bi-Level

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  Male  Female

### DIAGNOSIS

- COPD (496)       Emphysema (492.8)       Chronic Bronchitis (491.20)  
 Asthma (493.00)       OSA (780.57)       CHF (428.0)       Other: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Insurance Company: \_\_\_\_\_ Secondary Insurance Insurance Company: \_\_\_\_\_  
 ID#: \_\_\_\_\_ ID#: \_\_\_\_\_

### RESPIRATORY

Home Oxygen @ \_\_\_\_\_ LPM \_\_\_\_\_ Hrs Per Day  
 Via:  Nasal Cannula       Mask  
 Continuous       Nocturnal

Portable Oxygen @ \_\_\_\_\_ LPM

Humidifier for Oxygen  Yes  NO

Length of Need: \_\_\_\_\_

CPAP       BiPAP

Pressure: \_\_\_\_\_ EPAP: \_\_\_\_\_ IPAP: \_\_\_\_\_

Mask Size: \_\_\_\_\_ Back Up Rate: \_\_\_\_\_

Humidifier:  Yes  No Heated:  Yes  No

Sleep Study is required for CPAP/BiPAP Orders

Physician Name: \_\_\_\_\_

Physician Telephone: \_\_\_\_\_

### PATIENT ASSESSMENT

- Overnight, Spot Check Oximetry, Vital Signs  
 Spot Check Oximetry  
 Overnight Oximetry

### Nebulizer Medications

R<sub>x</sub> (Write in Medication Needed)

NR. 1 2 3 4 5 PRN \_\_\_\_\_ MD

### DME

- Hospital Bed       Wheelchair  
 Nebulizer       Walker  
 Other: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

FAX ORDERS TO: (712) 881-1206