**American HomeCare Equipment**
**Main Address:** 3200 N 29th. Ave. Hollywood, FL 33020
**Phone:** (954) 772-5052 Fax: (954) 772-5288
**West Palm Beach Address:** 6252 S. Congress Ave. Lantana, FL, 33462
**Phone:** (561) 469-2090 Fax: (561) 894 -5296

**Email:** customerservice@ahcequip.com
Parachute / Careport / Go Scripts / DME Scripts

# STANDARD WRITTEN ORDER
# OXYGEN SET UP

The following documentation is required by Medicare
for us to be able to supply oxygen

Name of patients:_____ DOB:_____/_____/_____

- ☐ Diagnosis:
- ☐ Chronic Obstructive Pulmonary Disease (COPD) (J44.9)
- ☐ Bronchiectasis (J47.9)
- ☐ Chronic Bronchitis (J42.0)
- ☐ Emphysema (J43.9)
- ☐ Pulmonary Hypertension (I27.0)
- ☐ Chronic CHF (I50.42)
- ☐ Chronic Pulmonary Edema
- ☐ Pleurar Effusion (J90)
- ☐ Other Chronic Lung Related Conditions:_____

Date Ordered: ____/____/_____ Months needed:_____(99=lifetime)

**Oxygen information:**

Discharge date: ___/___/_____

- ☐ OXYGEN CONCENTRATOR
- ☐ PORTABLE OXYGEN TANK

Liter Flow:_____LPM Duration:_____ Continuous

**Saturation Levels:**

Date test taken ____/___/_____ Test performed by: _____

O2 saturation levels must be done within two (2) days prior to discharge

O2 stauration level in room air at rest: _____%

O2 stauration level in room air at exertion: _____%

O2 stauration level on oxygen at exertion: _____%

Does the order have attached the original O2 Saturation test results? Yes____ No ____

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**I certify that I am actively treating this patient and that the information I provide is Accurate**

Physician Name:_____ NPI#_____

Address:_____

Signature:_____ Date:___/___/_____

**Please be advised** - We cannot deliver until all documentation required by MEDICARE is completed and received.