SSMHealth at Home

Oxygen RX

FAX COVER

To: _____ From: _____

Fax: _____ Pages: _____

Phone: _____ Date: _____

Message:

Remarks: ☐ Urgent ☐ For Your Review ☐ Please Comment ☐ Please Reply

Standard Written Order for Oxygen

Patient Name: _____ Date: _____

Patient Address: _____

	☐ Continuous	☐ With Activity	☐ NOC
	☐ Nasal Cannula	☐ Mask	☐ Humidification
Oxygen at _____ liter per minute	☐ Stationary Concentrator Including content and supplies	☐ Portable System Including content and supplies	☐ Cluster headache only – Stationary tanks

☐ Respiratory Conserving Device Evaluation to keep oxygen saturations above 88%

Diagnosis Code_____ Length of need: _____

Provider Name (please print): _____

Provider Signature: _____ Date: _____

Provider Address: _____

NPI#: _____