Detailed Written Order Prior to Delivery
Revision: DWO417

Date Last Seen by Doctor: ________________
(Medicare requires the patient visit within 30 days)

Initial Date ______________

PRO-AIR
Medical Supply & Equipment

Phone: (989) 355-1601 / 1-844-445-1122
Fax: (989) 355-1605 / 1-844-284-5628

Patient Name: ____ DOB: ________________
Address: ____ Phone: ________________
Diagnosis: ________________________________ Height: __________ Weight: __________

☐ **Overnight Pulse Oximetry** ☐ On Room Air ☐ On O2 ☐ On CPAP/BIPAP

☐ Oxygen-Nocturnal - L/M __________

If patients saturation is ≤ 88% on room air, patient qualifies for 24 hour oxygen.

☐ Oxygen 24 Hours w/Gaseous Portables – L/M______ Testing Date __________
Saturation on Room Air at Rest ______% (If saturation is ≤ 88%, **STOP**, patient qualifies)

☐ Oxygen 24 Hours w/Gaseous Portables (During Exercise) – L/M______ Testing Date __________
Patient Saturation ______% on Room Air at Rest
Patient Saturation ______% on Room Air while walking _______ feet
Patient Saturation ______% on Oxygen at ______ L/M while walking _______ feet

☐ Nebulizer Machine ☐ Disposable Med Cup/Neb Kit ☐ Reusable Med Cup/Neb Kit

☐ CPAP – CM of Pressure: __________ (Heated Humidifier & Supplies)
☐ BIPAP – CM of Pressure: _____ (Heated Humidifier & Supplies) ☐ With Backup Rate (if applicable) __________
☐ Auto CPAP/BIPAP (Heated Humidifier & Supplies) – Pressure ______________

☐ A7034 Nasal Mask (4/year)
☐ A7032 Cushions (2/month)
☐ A7033 Pillows (2/month)
☐ A7038 Disposable Filters (2/month)
☐ A7030 Full Face Mask (4/year)
☐ A7031 Cushions/Seal (1/month)
☐ A7037 Tubing (4/year)
☐ A7039 Non-Disposable Filters (1 every 6 months)
☐ A7046 Replacement Water Chamber (1 every 6 months)
☐ A4604 Heated Tubing (4/year)
☐ A7035 Headgear
☐ A7036 Chinstrap

PLEASE INCLUDE A COPY OF THE ORIGINAL SLEEP STUDY (IF AVAILABLE)

Bariatric = >350 lbs. - Heavy Duty = >300 lbs.

Ambulatory Aids/Other
☐ Standard Walker w/o Wheels
☐ Front Wheel Walker
☐ Rollator w/Seat
☐ Bariatric Walker
☐ Standard Cane
☐ Quad Cane
☐ Standard Crutches
☐ TENS Unit
☐ Suction Trach/Oral

Wheelchairs
☐ Standard Wheelchair
☐ Bariatric Wheelchair
☐ Standard Foot Rest
☐ Elevating Foot Rest
☐ Wheelchair Cushion
☐ Tension Adjustable Back

Bathroom Aids
☐ 3-N-1 Commode
☐ Heavy Duty Commode

Hospital Bed/Transfer Aids
☐ Standard Bed
☐ Bariatric Bed
☐ Gel Overlay
☐ APP
☐ Low Air Loss
☐ Patient Lift
☐ Slide Board
☐ Long ☐ Short

☐ Other: ______________________________ ☐ Facility: ______________________________

*** Duration of Need:** ________________ *** Physician's NPI Number:** ______________________

Physician's Name (Print): ______________________________ Phone: ________________

Physician's Signature: ______________________________ Date: ________________

PLEASE ALSO INCLUDE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION