Coastal Carolina Respicare

Phone: (910) 362-1414 **Fax: (910) 362-0464**

FAST FAX ORDERS

Patient Name: _____

D.O.B. _____ Primary Ins._____

SS# _____ Policy# _____

Address: _____ Secondary Ins._____

_____ Policy# _____

_____ Diagnosis: _____

Phone: _____ _____ _____

Ht: _____ inch/cm Wt: _____ lbs/kg Length of Need _____ 99 months=lifetime

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Physician Name: _____ Phone: _____ UPin# _____

___ Overnight Oximetry _____ Nebulizer Therapy

___ **Oxygen** ____ LPM ____Continuously _____%O2 sat/Po2 _____Date of Test

____Portable O2 ___ Conserving device /Pulse Dose

___ **CPAP** _____cm **Bi-Level Therapy** ___ IPAP ____ EPAP ____ Back up Rate

_____Mask Type ___ Humidification ___ Cool ___ Heated

___ Cane ____ single prong ____ four prong

___ Walker ___ Rolling ____ Standard ___Rollator ___Hemi

___ Wheelchair ___Lt Wt ___ STD ____ Elv Leg Rests ____ Std Leg Rests

___ Hospital Bed ____ low loss ____ APP

___ Trapeze Bar ___ free standing ___ Bed mounted _____ Hoyer Lift

___ 3 in 1 Bedside commode

___ Shower chair ___ w/ back ___ w/o back

___ Tub Transfer Bench ___Transfer Board

___ CPM _____ Date of Knee replacement _____ left or right

* Other items or accessories may be available upon request.

Faxed by: _____ Date: _____

Physician Signature_____ or attached signed prescription _____