



Coastal Carolina Respicare

Phone: (252) 948-1414

Fax: (252) 948-0142

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

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 _____