CAROLINA'S HOME MEDICAL EQUIPMENT

NAME OF FACILITY: _____
REFERRAL CONTACT: _____ PHONE: _____

Account Executive -Taylor Pigg; Phone (704) 441-5811 ; Office (704) 846-7503; Fax (704) 846-7911

Respiratory Equipment Detailed Written Order Prior to Delivery (DWOPD)

PATIENT'S NAME: _____ PHONE: _____

PATIENT'S HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

SNF/REHAB/HOSPITAL DISCHARGE DATE: _____

PRIMARY CARE PHYSICIAN'S NAME: _____

DIAGNOSIS: _____

EQUIPMENT NEEDED: (check items)

The items listed below REQUIRE office visit notes & a physician's VERBAL or SIGNED order prior to delivery.

□ PULSE OXIMETRY, overnight □ SUCTION MACHINE

The items listed below REQUIRE office visit notes & a physician's SIGNED order prior to delivery.

□ NEBULIZER, WITH COMPRESSOR
□ NEBULIZER SUPPLIES
□ HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM//AffloVest
_____Hz (Settings-5, 13 or 20Hz) □ SETTING MAY BE ADJUSTED FOR PATIENT COMFORT (Check box)
_____ LENGTH OF TREATMENT; _____ NUMBER OF TREATMENTS PER DAY

For all PAP Devices, please send office visit note, prior to sleep study, original sleep study & PAP titration reports.
Refer to PAP Detailed Written Order Prior to Delivery (DWOPD) for ordering.

For OXYGEN, please fill out this section:

Oxygen Equipment

□ STATIONARY OXYGEN CONCENTRATOR
□ (HOMEFILL) - PORTABLE COMPRESSED GASEOUS OXYGEN SYSTEM

O2 at _____ LPM via nasal cannula. **Continuous** OR **Nocturnal**
Pulse ox reading - _____% on room air obtained on _____ (date), while at (check one):
□ **rest** □ **exertion/exercise*** □ **sleeping**

***** If tested during exertion/exercise, there are 3 readings that are required:
1) O2 Sat at rest _____%,
2) O2 Sat during exercise _____%, and
3) O2 Sat during exercise while on O2 to show improvement of hypoxemia _____%.
All 3 tests must be performed in the same testing session/office visit.

Does this patient need humidification? **YES NO**

Frequency of Use Estimation? _____
Duration of use? _____

For portable oxygen:
Is patient mobile within their residence & require portable O2? **YES NO**
Is patient able to tolerate a conserving device? (Choose from 3 options.) □**YES** □ **NO**
□ **UNSURE**: RT titrate for conserving device, and if sats maintain at _____% or higher then dispense conserver.

Name of Referring Physician (Print): _____ **Length of Need:** _____

Physician's Signature: _____
(if not available, must have verbal order or doctor's order)

NPI: _____ **Start/Date of Order*:** _____

SUBSTITUTION PERMITTED TO PROVIDE A QUALIFYING SERVICE.
*** - MUST have start/date of order**