Phone: phone

Fax: fax

Physician's Order/Change

Date of order: ______________________

Physician's Name: ______________________ Patient Acct #: ______________________

Patient Name: ______________________ Date Of Birth: ______________________

HIC/ID#: ______________________

A home visit was completed by a Medical West employee on ____________

Our current oxygen settings indicates: ______________________

The patient has stated a change was made in their oxygen setting to the following. Please sign if the patient's liter flow has changed to:

OXYGEN THERAPY

☐ Liter flow change - new Liter per Minute ☐ **Discharge Oxygen Therapy**

☐ Continuous ________ lpm ☐ @ rest ________ ☐ exertion/activity ________ lpm

☐ Nocturnal ________ lpm ☐ PRN ________ ☐ Cannula ☐ Mask ☐ Bleed in via CPAP/BiPAP

☐ Change in **Portable** Oxygen System: ______________________

New System: ☐ Liquid portable system ☐ Other: ______________ **(Current System)**

☐ Re-evaluate Liter Flow ☐ Clinical walk study Current Liter Flow: ______ Recommended Liter Flow: ______

CPAP THERAPY

Pressure Change ☐ Increase ____________ ☐ Decrease ____________

Ramp ☐ Add ____________ Pressure ____________ Minutes ____________

Add ☐ Chin Strap ☐ Refit Interface ☐ **Discontinue CPAP/BiPAP Therapy**

NEBULIZER COMPRESSOR ☐ **Discontinue Nebulizer Therapy**

☐ Suction Machine and Supplies:

Other:

☐ **Discharge Billibed / Phototherapy**

Physician Name: ______________________ Physician NPI # ______________________

______________________ ______________

Physican's Signature **Date**

If you have any questions please contact Medical West and speak to: contact