Oximetry & Home Oxygen Rx

NorCal Respiratory
Diagnostic Home Sleep Testing

3075 Crossroads Drive
Redding, CA. 96003
Fax: 246-2023
Phone: 246-1200

Physician Name:		Physician Phone:
Patient Name:	DOB:	Patient Phone:
Diagnosis:		Diagnosis Code(s):

OXIMETRY TESTING

(*Screen for pulmonary dysfunction or sleep disordered breathing*)

☐ **Nocturnal oximetry test**

HOME OXYGEN

(Check One)

☐ **Nocturnal Only –** Including nocturnal oximetry test following oxygen therapy to assess oxygen therapy and appropriate flow rate.

☐ **Ambulatory/24 hours** – Including nocturnal oximetry test following oxygen therapy to assess oxygen therapy and appropriate flow rate.

O_2 Flow Rate/LPM: _____

Ambulatory/24 hour Patients Only – Equipment Preference (optional)

☐ **Portable Oxygen Concentrator (POC) System** – Includes: POC, stationary O_2 concentrator and back-up O_2 tanks.

☐ **Homefill™ Oxygen System –** Includes: Small portable refillable O_2 tanks and O_2 compressor for refilling tanks, plus stationary O_2 concentrator.

Other physician instructions/directions:

Physician/Provider Signature_____Date:_____

Please fax:

1. **This signed Rx.**
2. **Patient's cover sheet including insurance and demographics.**
3. ***For oxygen patients only:* Provider's chart notes justifying the need for home oxygen.**

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