

CapOx (ETCO₂ & ONO) Order Form



Customer Support: (877) 337-7111
Web: www.virtuox.net

Phone: _____
Fax: _____

Prescription and Clinical Evaluation

Patient Information:

Name: _____ Gender: _____ DOB: _____
First Last
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Insurance: Check here if self-pay

Primary Payer: _____ ID#: _____ Group#: _____ Phone: _____
 Secondary Payer: _____ ID#: _____ Group#: _____ Phone: _____

Prescriber Information:

Name: _____ NPI: _____
First Last
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____

Diagnostic Order:

Overnight Oximetry / Awake Oximetry: Immediately and repeat in 30 60 90 Other _____ days to validate oxygen settings.

Test Condition:

Room Air Oxygen: _____ APAP / CPAP / BIPAP: _____ Dental Device Other: _____

Diagnostic Codes: (Check all ICD-10 codes that apply)

Respiratory Related Codes	Cardiac Related Codes
<input type="checkbox"/> C34.90 Malignant neoplasm of unspecified part of bronchus or lung	<input type="checkbox"/> I50.30 Unspecified diastolic (congestive) heart failure
<input type="checkbox"/> J44.9 Chronic obstructive pulmonary disease, unspecified	<input type="checkbox"/> I50.31 Acute diastolic (congestive) heart failure
<input type="checkbox"/> J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	<input type="checkbox"/> I50.32 Chronic diastolic (congestive) heart failure
<input type="checkbox"/> J43.9 Emphysema Unspecified	<input type="checkbox"/> I50.33 Acute on chronic diastolic (congestive) heart failure
<input type="checkbox"/> J45.20 Mild intermittent asthma, uncomplicated	<input type="checkbox"/> I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J45.22 Mild intermittent asthma with status asthmaticus	<input type="checkbox"/> I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J45.21 Mild intermittent asthma with (acute) exacerbation	<input type="checkbox"/> I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J45.909 Unspecified asthma, uncomplicated	<input type="checkbox"/> I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J47.9 Bronchiectasis, uncomplicated	<input type="checkbox"/> I50.9 Heart failure, unspecified
<input type="checkbox"/> J47.1 Bronchiectasis with (acute) exacerbation	<input type="checkbox"/> I01.8 Other acute rheumatic heart disease
<input type="checkbox"/> J84.10 Post Inflammatory Pulmonary Fibrosis	<input type="checkbox"/> I09.81 Rheumatic Heart Failure (congestive)
<input type="checkbox"/> J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia	<input type="checkbox"/> I27.0 Primary Pulmonary Hypertension
<input type="checkbox"/> R40.0 Somnolence	<input type="checkbox"/> I27.89 Other specified pulmonary heart disease
<input type="checkbox"/> R40.1 Stupor	<input type="checkbox"/> I27.9 Pulmonary Heart Disease, Unspecified
<input type="checkbox"/> R06.02 Shortness of Breath	<input type="checkbox"/> I50.9 Congestive Heart Failure, Unspecified
<input type="checkbox"/> R06.82 Tachypnea / Rapid Breathing	<input type="checkbox"/> I50.1 Left Heart Failure
<input type="checkbox"/> R06.2 Wheezing	<input type="checkbox"/> I50.20 Unspecified systolic (congestive) heart failure
<input type="checkbox"/> R06.00 Dyspnea	<input type="checkbox"/> I50.21 Acute systolic (congestive) heart failure
<input type="checkbox"/> R06.83 Snoring	<input type="checkbox"/> I50.22 Chronic systolic (congestive) heart failure
<input type="checkbox"/> R09.01 Asphyxia	<input type="checkbox"/> I50.23 Acute on chronic systolic (congestive) heart failure
<input type="checkbox"/> R09.02 Hypoxia / Hypoxemia	
	Other: _____
	* Date Patient Last Seen: ____ / ____ / ____

My signature below certifies that the named patient above is having:
 An awake / overnight oximetry to determine if the patient desaturates while sleeping, and / or qualifies for home nocturnal oxygen.
 An awake / overnight exhaled gas collection to determine if the patient has high CO₂ levels while awake / sleeping to determine non-invasive ventilation medical necessity.

Physician Signature: _____ **Date:** _____

Please fax completed order form & insurance card back to (800) 566-1959