Local Respiratory Provider – Oximetry Courier

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Nationwide Independent Diagnostic Testing Facility

Phone: (877) 337-7111 Fax: (800) 566-1959
Web: www.virtuox.net

Respiratory Test Order Form

Patient Information:

Name: _____ Sex: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance: *(Copies of Private Insurance cards must be faxed for all non-Medicare referrals)*

Payor Name 1: _____ ID#: _____ Group#: _____ Phone: _____

Payor Name 2: _____ ID#: _____ Group#: _____ Phone: _____

Physician Information:

Name: _____ NPI: _____ Phone: _____ Fax: _____

Overnight Oximetry: *Does your Patient have any Lung / Cardiac Symptoms that may require Nocturnal Oxygen?*

Respiratory Related Codes:

___ C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
___ J44.9 Chronic obstructive pulmonary disease, unspecified
___ J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
___ J43.9 Emphysema Unspecified
___ J45.20 Mild intermittent asthma, uncomplicated
___ J45.22 Mild intermittent asthma with status asthmaticus
___ J45.21 Mild intermittent asthma with (Acute) exacerbation
___ J45.909 Unspecified asthma, uncomplicated
___ J47.9 Bronchiectasis, uncomplicated
___ J47.1 Bronchiectasis with (Acute) exacerbation
___ J84.10 Post Inflammatory Pulmonary Fibrosis
___ J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
___ R40.0 Somnolence
___ R40.1 Stupor
___ R06.02 Shortness of Breath
___ R06.82 Tachypnea / Rapid Breathing
___ R06.2 Wheezing
___ R06.00 Dyspnea
___ R06.83 Snoring
___ R09.01 Asphyxia
___ R09.0 Hypoxia / Hypoxemia

Cardiac Related Codes:

___ I50.30 Unspecified diastolic (congestive) heart failure
___ I50.31 Acute diastolic (congestive) heart failure
___ I50.32 Chronic diastolic (congestive) heart failure
___ I50.33 Acute on chronic diastolic (congestive) heart failure
___ I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
___ I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
___ I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
___ I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
___ I50.9 Heart failure, unspecified
___ I01.8 Other acute rheumatic heart disease
___ I09.81 Rheumatic Heart Failure (Congestive)
___ I27.0 Primary Pulmonary Hypertension
___ I27.89 Other specified pulmonary heart diseases
___ I27.9 Pulmonary Heart Disease, Unspecified
___ I50.9 Congestive Heart Failure, Unspecified
___ I50.1 Left Heart Failure
___ I50.20 Unspecified systolic (congestive) heart failure
___ I50.21 Acute systolic (congestive) heart failure
___ I50.22 Chronic systolic (congestive) heart failure
___ I50.23 Acute on chronic systolic (congestive) heart failure

Diagnostic Orders: *Awake Oximetry CPT 94760 & Overnight Oximetry CPT 94762*

Immediately and repeat in 30 / 60 / 90 / other: _____

Room Air: ____ Oxygen: ____ APAP: ____ CPAP: ____ BIPAP: ____

Dental Device: ____ Other: _____

Date Patient Last Seen: _____ /_____ /_____

Physician Signature & Certification:

(Stamped dates/signatures not valid. Must be signed by Physician/PA/NP)

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.

MD Signature: _____ Date: _____

Home Sleep Testing: *Does your patient have any Sleep Apnea Symptoms that may require CPAP?*

Diagnosis Codes:

___ G47.30 Apnea, Unspecified
___ G47.30 Hypersomnia with Sleep Apnea, Unspecified
___ G47.30 Insomnia with Sleep Apnea, Unspecified
___ R09.02 Hypoxemia
___ G47.30 Sleep Apnea, Unspecified
___ G47.33 Sleep Apnea, Adult Pediatric

Sleep History & Physical Exam: (fill in blanks/check symptoms)

Height: _____ inches Weight: _____ lbs BMI: _____

Neck Size: _____ inches Sleep Epworth Score: _____ (0-24)

___ Sleep Disordered Breathing
___ Excessive Daytime Sleepiness
___ Non-Restorative Sleep
___ Depression
___ Dry mouth in a.m.
___ Oral Appliance Assessment
___ Loud Snoring
___ Morning Headaches
___ Gasping/Choking
___ Observed Apnea

Cardiopulmonary / Upper Airway Exam: (check all that apply)

___ Nasal Obstruction
___ Maxillomandibular abnormality
___ Enlarged Tongue
___ Crowded Oropharynx
___ Obesity
___ Retrognathia/Micrognathia
___ Teeth Worn
___ Over / Under Bite
___ Crowded Hypopharynx
___ Enlarged Tonsils
___ Hypertension

Home Sleep Test Procedure:

2-night Unattended, Type III Portable Recorder with minimum four (4) channels: Records airflow, respiratory effort, O_2 saturation, and heart rate. Performed on room air unless specified below.

___ Test on Oxygen - check here if test is to be performed with patient on current O_2 prescription

Date Patient Last Seen: _____ /_____ /_____

Physician Signature & Certification:

(Stamped dates/signatures not valid. Must be signed by Physician/PA/NP)

I, the undersigned, certify that I am the patient's treating physician and that the information contained on this form is based on a face-to-face office visit. I am prescribing a two-night serial HST as medically necessary to validate results because of night to night variability.

MD Signature: _____ Date: _____

Please fax this order form back to (800) 566-1959