Local Respiratory Provider – Oximetry Courier

_____
_____
_____
_____

Nationwide Independent Diagnostic Testing Facility

Phone: (877) 337-7111 Fax: (888) 635-8254
Web: www.virtuox.net

VO2 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: _____

Diagnostic Orders:

Overnight Oximetry / Awake Oximetry: Immediately and repeat in 30 / 60 / 90 / other: _____ to validate Oxygen settings.

Test will be conducted for 2 consecutive nights: Night one: Test on current FI02/LPM Night two: Test on Room Air _____

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

Qualifying Diagnosis:

Respiratory Related Codes

___ C34.90 Malignant neoplasm of unspecified part of 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
___ R09.02 Hypoxia / Hypoxemia

Sleep Related 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

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 disease
___ 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

___ **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.

Physician Signature: _____ **Date:** _____