



Patient Evaluation

Prescription Order Form

Phone: (352) 293-2810 / Fax: (352) 274-9122

Patient Information

Patient Name: _____ Male Female

DOB: ____ / ____ / ____ Phone: _____ Other: _____

Address: _____ City/State/Zip: _____

Primary Ins: _____ ID #: _____

Secondary Ins: _____ ID #: _____

Fax copy of Insurance Card(s), front & back, if available.

Local DME Supplier: _____ Contact: _____

Phone: _____ Fax: _____ Email: _____

Prescription Orders

Oxygen Evaluation	Sleep Evaluation	Home Compliance Visit(s)
<input type="checkbox"/> Home Oxygen Evaluation (Home Visit to determine the need for home oxygen.) Includes Simple Stress Test and/or Nocturnal Pulse Oximetry. <input type="checkbox"/> Room Air (RA) <input type="checkbox"/> Oxygen (O2) <i>(If O2 Test, _____ LPM)</i> <input type="checkbox"/> Nocturnal Pulse Oximetry (Home Visit to determine the need for nocturnal home oxygen through a pulse oximetry test.) <input type="checkbox"/> Room Air (RA) <input type="checkbox"/> Oxygen (O2) <i>(If O2 Test, _____ LPM)</i>	<input type="checkbox"/> Home Sleep Test Home Visit with Type II or Type III device to evaluate and diagnose a patient for suspected Obstructive Sleep Apnea (OSA). Type of Study <input type="checkbox"/> Room Air (RA) <input type="checkbox"/> Oxygen (O2) <i>(If O2 Test, _____ LPM)</i> <input type="checkbox"/> One (1) Night <input type="checkbox"/> Two (2) Night	<input type="checkbox"/> Home O2 Compliance Monitor & Evaluate the patient for home oxygen through home visits, teaching and education. Intervals <input type="checkbox"/> 4 Mon. <input type="checkbox"/> 6 Mon. <input type="checkbox"/> 12 Mon. <input type="checkbox"/> Other: _____ <input type="checkbox"/> CPAP Compliance Monitor & Evaluate the patient for CPAP usage through home visits, teaching and education (6 Mon.)

Patient Diagnosis

496 (COPD) 786.05 (SOB) 786.09 (Resp. Abnorm.) 492.8 (Other Emphysema) 493.00 (Unspec. Asthma) 515 (Pulm. Fibrosis)
 780.57 (Unspec. Apnea) Other: _____

Other Prescription Orders:

Referring Physician

Physician/Practitioner: _____ NPI: _____

Phone: _____ Fax: _____ Email: _____

Physician Certification I, the undersigned, authorize ADSI to complete the above diagnostic script for the named patient above. I also understand that there are certain criteria that must be met prior to ordering diagnostic tests which have been documented in the patient's medical record. By signing below I authorize ADSI to contact the patient to complete the prescription and perform the diagnostic test(s) through a home visit evaluation.

Signature: _____ Date: ____ / ____ / ____