Jonesboro
P 870-333-1230
F 870-333-1233

Mountain Home
P 870-656-4140
F 870-701-5095

Batesville
P 870-612-0049
F 870-283-7334

Cave City
P 870-283-7333
F 870-283-7334

Delta Medical

"Making Life a Bit Easier"

www.ARdeltamedical.com contactus@ARdeltamedical.com

Fayetteville
P 479-935-4949
F 479-935-4741

Rogers
P 479-268-5639
F 479-268-5836

Fort Smith
P 479-434-4923
F 479-434-5363

PHYSICIANS PRESCRIPTION FORM

Patient Name: ____________________ D.O.B. __________

Physician: ____________________ Height: __________

NPI: __________ Length of Need: ____ Weight: __________

Please fax face sheet (insurance/demographics) along with this form.

By my signature below, I authorize the use of this document as a dispensing prescription. My medical records support the need for the items prescribed.

DIAGNOSIS: ICD-10 Codes

- ☐ R09.02 Hypoxemia
- ☐ G47.33 OSA
- ☐ J98.9 Respiratory Abnormalities
- ☐ J44.9 COPD
- ☐ I50.9 Congestive Heart Failure
- ☐ I25.1 Coronary Artery Disease
- ☐ M62.81 Muscle Weakness
- ☐ M48.9 Gait Abnormality
- ☐ M19.90 Osteoarthritis
- ☐ J47.9 Bronchiectasis, w/ CT Scan
- ☐ J45.20 Asthma
- ☐ R06.02 Shortness of Breath
- ☐ J18.9 Pneumonia
- ☐ C34.80 Lung Cancer
- ☐ J96.00 Respiratory Failure
- ☐ R53.81 Fatigue / Malaise
- ☐ M54.5 Lumbar Pain
- ☐ M51.37 DJD
- ☐ M24.562 Contracture, Left Knee
- ☐ M24.561 Contracture, Right Knee

Other Dx: ____________________ **ICD-10** __________

Other Dx: ____________________ **ICD-10** __________

- ☐ Non-Invasive Vent (i.e. "Trilogy") (E0466)
- ☐ Hospital Bed (Semi-Electric) (E0260)
- ☐ Afflovest (E0483)
- ☐ Trapeze Bar (E0910)
- ☐ Hoyer Lift (E0630)
- ☐ Quad or Single Point Cane (E0105)
- ☐ Bedside 3-in-1 Commode (E0163)
- ☐ Tub Transfer Bench (E0248)
- ☐ Shower Chair (E0240)
- ☐ Walker with 5" Wheels (E0141)
- ☐ Rollator (E0141 & E0156)
- ☐ Wheelchair (K0003) Anti-Tip (E0971)
  - ☐ Seat/Back Cushions (E2601 & E2611)
  - ☐ Elevated Leg Rests (K0195)
  - ☐ Unable to Propel Standard Wheelchair
  - ☐ Can Propel Lightweight Wheelchair
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

OXYGEN

☐ **OXIMETRY REQUEST**

Overnight oximetry testing for qualifying purposes (CPT 94762)

☐**On Room Air** ☐**On CPAP/BiPAP**

OR

☐**On** __________ **LPM or % FiO2**

LPM __________

( ) Continuous ( ) Sleeping ( ) Activity

(x) Per Nasal Cannula ( ) Concentrator (E1390)

( ) Conserving Device with Walk Study (E0431)

SA02 __________ **%**

( ) Overnight ( ) At Rest ( ) with Activity / Test Date: __________

AEROSOL THERAPY

_____ Nebulizer/Compressor (E0570) _____ Neb Kits Neb Medications? ____________________

Hospitalizations this year? __________ How many times? __________

BRACING & SUPPORTS (circle side)

- ☐ Back Brace (L0650)
- ☐ Knee Brace: Left Right Bilateral (L1820)
- ☐ Crutches (E0114)
- ☐ Ankle Brace: Left Right Bilateral (L1832)
- ☐ Wrist Brace: Left Right Bilateral (L3908)
- ☐ Boot Walker: Left Right Bilateral (L4360)

Physician Signature: ***Date:***