



ALLIED MEDCOR SERVICES, INC.  
 Home Medical Equipment & Oxygen Therapy  
 4638 E. Grant Road  
 Tucson, AZ 85712  
 Phone (520) 296-5925 Fax (520) 777-4951

**RESPIRATORY / DURABLE MEDICAL EQUIPMENT ORDER**

Patient \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_  M  F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
 Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

<input type="checkbox"/> COPD (496)	<input type="checkbox"/> Emphysema (492.8)	<input type="checkbox"/> Chronic Bronchitis (491.20)
<input type="checkbox"/> Asthma (493.00)	<input type="checkbox"/> OSA (327.23)	<input type="checkbox"/> CHF (428.0)
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

**Respiratory Equipment**

- Home Oxygen @ \_\_\_\_\_ LPM \_\_\_\_\_ Hrs Per Day Via:  Nasal Cannula  Mask
- Portable Oxygen @ \_\_\_\_\_ LPM Humidifier for Oxygen:  Yes  No
- Nebulizer Compressor (SVN)

Oximetry Room Air Sat: \_\_\_\_\_%  @ Rest  Sleep (must be 5 minutes)  \*Exercise  
 • If qualifying test at exercise, O<sub>2</sub> sat while on prescribed oxygen: \_\_\_\_\_%

ABG: PaO<sub>2</sub> \_\_\_\_\_ mmHg Test Date: \_\_\_\_\_  
 Testing Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

- Estimated length of need: \_\_\_\_\_ months (99 months = Lifetime)

**Durable Medical Equipment**

<input type="checkbox"/> Semi-Electric Hospital Bed	<input type="checkbox"/> Standard Wheelchair	<input type="checkbox"/> Lightweight Wheelchair	<input type="checkbox"/> Heavy Duty Wheelchair
<input type="checkbox"/> Elevating Leg Rests	<input type="checkbox"/> Rollator (4 wheeled walker w/seat)	<input type="checkbox"/> Front Wheeled Walker	<input type="checkbox"/> Bedside Commode (3-n-1)
<input type="checkbox"/> Shower Chair	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Special Instructions: \_\_\_\_\_  
 \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Physician Printed Name \_\_\_\_\_ NPI \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_