BARNES HEALTHCARE SERVICES

Respiratory Services Prescription

Check all that apply

Patient Name: _____ MRN: _____ DOB: _____

Address: _____ ❑ Male ❑ Female Height: _____ Weight: _____

City: _____ State: _____ Zip: _____ Order Date: _____

DIAGNOSIS ICD-10 CODE REQUIRED

ICD-10	Diagnosis	ICD-10	Diagnosis	ICD-10	Diagnosis
_____	Lung Cancer	_____	Asthma	_____	Hypoventilation
_____	Cardiac Disease	_____	Bronchiectasis w/o Acute Exacerbation	_____	Obesity Hypoventilation Syndrome
_____	Congestive Heart Failure	_____	Bronchiectasis w/ Acute Exacerbation	_____	ALS
_____	Respiratory Failure	_____	COPD	_____	Myasthenia Gravis
_____	Bacterial Pneumonia	_____	Black Lung	_____	Muscular Dystrophy
_____	Chronic Bronchitis	_____	Asbestosis	_____	Pulmonary Fibrosis
_____	Emphysema	_____	Hypoxemia	_____	_____

OXIMETRY STUDY ORDERS

Overnight @ Sleep On: ☐ Room Air ☐ Oxygen ☐ CPAP _____cm

Awake and at Rest on: ☐ Room Air ☐ Oxygen

☐ 6 Minute walk test: to include room air at rest, room air during exertion, on O^2 during exertion

OXYGEN

☐ Initial ☐ Renewal ☐ Revision Length of Need _____ (# Months) ☐ Lifetime

Oxygen RX: O_2 via ☐ N/C or ☐ PAP @ _____ **LPM to be used:** ☐ Continuous ☐ Nocturnal

☐ Concentrator ☐ Portability ☐ **E0443 Portable O_2 contents, gas** ☐ K0738 Homefill Portable ☐ E1392 POC

Conserving Device Orders: ☐ Use conserving device at _____ setting ☐ May increase liter per minute up to _____ for exercise / exertion.

☐ RT to titrate O_2 settings to keep patient's O_2 saturation ≥ 90% with any conserving device ordered.

CLINICAL RESPIRATORY SERVICES

Clinical Respiratory Assessment: ☐ Ongoing (12 months) ☐ One Time

☐ Teach and train (non-patient contact) please specify: _____

Desired non-emergent clinical interventions: _____

NEBULIZER AND MEDICATION ORDERS

☐ E0570 Nebulizer ☐ A7003 Disposable Neb Circuit 2 / 1 mo ☐ A7005 Non Disposable Neb Circuit 1 / 6 mo ☐ A7015 Aerosol Mask 1 / 1 mo

Drug: ☐ Albuterol 0.083% 2.5mg / 3mL ☐ Ipratropium 0.02% 0.5mg / 2.5mL ☐ DuoNeb (Ipr 0.5mg / Albuterol 0.083%) / 3mL

☐ Pulmicort(Budesonide) 0.25mg / 2mL ☐ Pulmicort(Budesonide) 0.5mg / 2mL ☐ Pulmicort(Budesonide) 1 mg / 2mL

☐ Perforomist 20mcg / 2 mL ☐ Brovana 15mcg / 2 mL ☐ Other: _____

Quantity to Dispense: _____ Number of Refills: _____ Length of Need: _____

Directions: Patient to Inhale _____ vial of selected medication as directed by prescriber via nebulizer every:

☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ 12 hrs ☐ 24 hrs ☐ Other: _____

Verbal Orders

☐ VORB (VORB / Prescriber Name / BHCS Rep name / Credentials (Title) / Initials BHCS Rep) ☐ Order Clarification

Barnes Healthcare Services Representative Signature: _____ Date: _____

PRESCRIBER SIGNATURE

Prescriber Name: _____ Phone Number: _____

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

Prescriber Signature: _____ NPI: _____

Date: _____ License#: _____