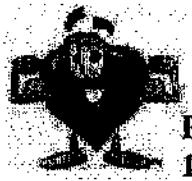

Three in One Respiratory Fax

Fax: 1-800-309-9196

Voice: 1-800-798-5053

Patient Name:_____ Phone:_____

Address: _____

_____DOB:_____

Medicare #:_____ Secondary Insurance : _____

Diagnosis: ☐ COPD 496 ☐ Chronic Asthma 493.20 ☐ Chronic Bronchitis 491.90
☐ Bronchiectisis 494.00 ☐ Emphysema 492.8 ☐ CHF 428.0 ☐ Hypoxemia 799.02
☐ Sleep Apnea 780.57 ☐ Other_____

1 Assessment provided by *AmEx Disease Management*

*Note: If this patient is a government reimbursed beneficiary, AmEx DM may refer the qualifying testing to a separate IDTF.

☐ **Respiratory assessment including Oximetry at rest, exertion, nocturnal & 6 minute simple stress pre & post exertion Spirometry & post bronchodilator.** 94620 & 94762
Which bronchodilator? _____Semi-annually or other ☐ _____
☐ I will submit a claim for the professional component of the tests.
Spirometry ☐ Simple 94010 ☐ Pre & Post Bronchodilator 94060 ☐ In Home Sleep Test G0399
Oximetry* ☐ Spot Check ☐ Exertion ☐ Overnight includes OSA Indicator
☐ **RespiCheck** (COPD Education and Care Plan) ☐ **StepByStep** (CHF Education & Assessment)

2 Equipment provided by *RespiCare*

☐ Oxygen @ _____LPM ☐ Nasal Cannula ☐ Nocturnal/PRN ☐ 24Hours/day
☐ Compressor Nebulizer ☐ Pari Neb Kit ☐ Disposable Neb Kit ☐ AeroNeb Portable Nebulizer
☐ CPAP Therapy _____cmH2O _____ Ramp _____ C-Flex
☐ BiLevel Therapy ____IPAP ____EPAP _____
Mask Type: _____ Mask Size: _____
☐ Heated or ☐ Cool Humidification
Special Instructions:_____

3 Medication provided by *AmEx Pharmacy*

I give permission to ***RespiCare*** to act as my agent in transmitting this written prescription to the pharmacy of the patient's choice.

☐ Albuterol 0.083% 3ml ☐ Ipratropium 0.02% 2.5ml ☐ Xopenex 1.25mg 3ml
☐ Albut. 3.0mg/Iprat. 0.5mg 3ml ☐ Budesonide 0.5mg 2.5ml ☐ Brovana 15mcg 2ml
☐ Other: _____ QUANTITY: 30 Day or :_____ REFILLS: 1 Year or :_____
Frequency: ☐ QID ☐ TID ☐ BID ☐ Other: _____

Dr. Josee Arcand *NPI#* 1710061726

Address 21 Suntree Place Suite 102 *Phone* (321) 255 -7334

Melbourne, FL 32940 *Fax* (321) 255 -7336

_____ _____

Physician Signature Date