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OVERNIGHT OXIMETRY TESTING PRESCRIPTION

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ CITY/ST/ZIP: _____
PHONE: _____ SSN: _____ GENDER: M: F:
DME PROVIDER: NAME: _____ PHONE: _____
CITY: _____ ST: _____ FAX: _____

NOTICE: THE DME PROVIDER LISTED ABOVE IS NOT AFFILIATED WITH DIAGNOSTIC MEDICAL TESTING. THE DME PROVIDER WILL DELIVER THE PULSE OXIMETRY TESTING EQUIPMENT TO THE PATIENT, RETRIEVE THE EQUIPMENT AND ELECTRONICALLY TRANSMIT THE DATA FROM THE EQUIPMENT TO DIAGNOSTIC MEDICAL TESTING. ANY QUESTIONS RELATED TO THE USE OR OPERATION OF THE PULSE OXIMETRY TESTING EQUIPMENT OR YOUR TEST SHOULD BE DIRECTED TO DIAGNOSTIC MEDICAL TESTING.

PRESCRIPTION / DIAGNOSIS - TO BE COMPLETED BY THE PHYSICIAN

DESCRIPTION OF SERVICES INCLUDED BY PRESCRIPTION:

94762 -- ON ROOM AIR 94762 -- ON O2 @ _____ LPM 94762 -- ON CPAP / BIPAP

DIAGNOSIS (PLEASE CHECK ALL THAT APPLY):

CHF COPD DYSPNEA / HYPOXIA HEART FAILURE UNSPECIFIED EMPHYSEMA SOB OSA
 SLEEP APNEA RESPIRATORY ABNORMALITY OTHER: _____

PHYSICIAN ATTESTATION AND SIGNATURE / DATE

I CERTIFY THAT I AM THE TREATING PHYSICIAN AS IDENTIFIED ON THIS FORM. ANY STATEMENT HAS BEEN REVIEWED AND SIGNED BY ME. I CERTIFY THAT THE INFORMATION ABOVE IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND UNDERSTAND THAT ANY FALSIFICATION, OMISSION OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

X PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S NAME PRINTED: _____

NPI #: _____ FAX: _____

UPIN #: _____ PHONE: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PLEASE FAX COMPLETED PRESCRIPTION TO: