



**Home Medical Visits**  
 Diagnostic Medical Testing  
 Patient's Are Our First Priority

Tel: (877) 202-1191 \* Fax: (866) 637-2890

**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: