Hayat
Home Medical Equipment

OXYGEN INTAKE FORM

CUSTOMER INFORMATION:

Name:	DOB:
Phone #:	Address:

PHYSICIAN INFORMATION:

PHYSICIAN NPI:

ADDRESS:

FAX:

PHONE:

SPECIALTY:

HOME OXYGEN ORDER INFORMATION:

DX Code:	DX:
DX Code:	DX:

Equipment needed (must select either POC or Tanks): ( ) Portable Oxygen Unit
( ) Stationary Unit ( ) Oxygen Tanks ( ) POC Evaluation needed

Test Method: 02 SAT % ( ) At Rest SAT % ( ) With Exercise O2 SAT
% ( ) During Sleep Test Date: / /

Method of Administration: ( ) Nasal Cannula ( ) Mask
Flow Rate LPM: _____ ( ) Nightly ( ) Continuous
Length of need: _____ (Months) (99 = lifetime)

Date / / Physician signature:

3518 W 95TH St. Evergreen Park, IL, 60805
TEL 708-422-2300 EXT 131 FAX 708-422-5966