SHIELDS HOME MEDICAL

HOME MEDICAL EQUIPMENT & SUPPLIES
623 W. MAIN STREET WALNUT RIDGE, ARKANSAS 72476
T: 870.886.2002 F: 870.886.1863

OVERNIGHT OXIMETRY PRESCRIPTION

ORDER DATE:	**START DATE (IF DIFFERENT):**
TEST TYPE (PLEASE CHECK ONE): □ ON ROOM AIR □ ON OXYGEN @ ___LPM □ ON CPAP/BIPAP/APAP	
SPECIAL INSTRUCTIONS:	

GENERAL INFORMATION	**PRIMARY INSURANCE INFORMATION**
PATIENT NAME:_____ DOB: _____ /_____ / _____ ADDRESS: _____ _____ CITY: _____ STATE: _____ ZIP: _____	INSURANCE COMPANY: _____ _____ POLICY HOLDER DOB: _____ / _____ / _____ SUBSCRIBER ID: _____ GROUP # (IF APPLICABLE):_____

DIAGNOSIS (PLEASE CHECK ONE):

□ G47.10 HYPERSOMNIA	□ J43.8 EMPHYSEMA	□ R06.02 SHORTNESS OF BREATH
□ G47.30 UNSPECIFIED SA	□ J43.9 EMPHYSEMA UNSPEC.	□ RO6.89 RESP. ABNORMALITY
□ I27.0 PULUMONARY HTN	□ J44.9 COPD	□ R09.02 HYPOXEMIA
□ I27.81 COR PULMONALE	□ J45.901 ASHMA-ACUTE	□ OTHER:_____
□ I27.89 HEART DISEASE	□ J45.998 ASHMA-UNSPEC.	_____
□ I27.9 PUL. HEART DISEASE	□ J84.10 PULMONARY FIBROSIS	
□ I50.9 HEART FAILURE-UNSPEC.	□ J96.10 CHRONIC RESPIRATORY FAILURE	

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF):	**HOME MEDICAL EQUIPMENT SUPPLIER:**
ADVANCED DIAGNOSTIC SOLUTIONS, INC. 6125 SHERWIN DRIVE PORT RICHEY, FL. 34668 T: 352.293.2810 F: 352.274.9122 www.dynamicdiagnotic.com info@dynamaicdiagnostic.com	SHIELDS HOME MEDICAL EQUIPMENT 623 WEST MAIN STREET WALNUT RIDGE, AR. 72476 T: 870.886.2002 F: 870.886.1863

By signing below, I certify that I am ordering an overnight pulse oximetry (94762) for this patient listed on this prescription. The DME company shall courier the pulse oximeter and process the data electronically through the IDTF listed above.

PHYSICIAN SIGNATURE: _____ NPI: _____ DATE:_____