COOPER
Medical Supplies

Phone: 706-266-4086 Fax: 706-622-2394
Website: www.coopermedical.com
email: customerservice@coopermedical.com

Prescription for Oxygen

Date of Order:_____

Patient Demographics:

Name: _____Sex:_____DOB:_____
Address: _____City:_____ State:_____ Zip:_____
Home phone:_____Work phone:_____

Referring Physician Demographics:

Physician Name: _____ UPIN:_____ NPI:_____

Oxygen Prescription:

_____**Stationary Concentrator** _____**Portable Oxygen Concentrator**

Portable Use (if applicable):

_____**Conserving Device with Tanks (M-6 Tanks with Shoulder Bag)**

Y / N Has Patient Been Tested for Tolerance of Conserving Device

_____**E Tanks with Continuous Flow Regulator**

Settings:

Liter Flow: _____lpm at rest, _____lpm during activity, _____lpm during sleep

Please Check Applicable:
_____**Nocturnal Use**
_____**Bleed into CPAP/BiPAP**
_____**24 Hour Use**
_____**Use During Exercise**
_____**Use for Cluster Headaches**

Diagnosis Code(s):_____

Comments:_____

_____

Physician Signature:_____ **Date:**_____