



Phone: (877) 337-7111 Fax: (800) 566-1959
 Web: www.virtuox.net

Overnight Oximetry Order Form

Patient Information:

Name: _____ Sex: _____ DOB: _____ SS#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance: (Copies of Private Insurance cards must be faxed for all non-Medicare referrals)

Payor Name 1: _____ ID#: _____ Group#: _____ Phone: _____
 Payor Name 2: _____ ID#: _____ Group#: _____ Phone: _____

Physician Information:

Name: _____ NPI: _____ Phone: _____ Fax: _____

Diagnostic Orders:

Overnight Oximetry / Awake Oximetry: Immediately and repeat in 30 / 60 / 90 / other: _____ to validate Oxygen settings.

Room Air: _____ Oxygen: _____ APAP/CPAP/BIPAP: _____ Dental Device: _____ Other: _____

Qualifying Diagnosis:

Respiratory Related Codes	Cardiac Related Codes
<ul style="list-style-type: none"> ___ C34.90 Malignant neoplasm of unspecified part of bronchus or lung ___ J44.9 Chronic obstructive pulmonary disease, unspecified ___ J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation ___ J43.9 Emphysema Unspecified ___ J45.20 Mild intermittent asthma, uncomplicated ___ J45.22 Mild intermittent asthma with status asthmaticus ___ J45.21 Mild intermittent asthma with (acute) exacerbation ___ J45.909 Unspecified asthma, uncomplicated ___ J47.9 Bronchiectasis, uncomplicated ___ J47.1 Bronchiectasis with (acute) exacerbation ___ J84.10 Post Inflammatory Pulmonary Fibrosis ___ J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia ___ R40.0 Somnolence ___ R40.1 Stupor ___ R06.02 Shortness of Breath ___ R06.82 Tachypnea / Rapid Breathing ___ R06.2 Wheezing ___ R06.00 Dyspnea ___ R06.83 Snoring ___ R09.01 Asphyxia ___ R09.02 Hypoxia / Hypoxemia 	<ul style="list-style-type: none"> ___ I50.30 Unspecified diastolic (congestive) heart failure ___ I50.31 Acute diastolic (congestive) heart failure ___ I50.32 Chronic diastolic (congestive) heart failure ___ I50.33 Acute on chronic diastolic (congestive) heart failure ___ I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure ___ I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure ___ I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure ___ I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure ___ I50.9 Heart failure, unspecified ___ I01.8 Other acute rheumatic heart disease ___ I09.81 Rheumatic Heart Failure (congestive) ___ I27.0 Primary Pulmonary Hypertension ___ I27.89 Other specified pulmonary heart disease ___ I27.9 Pulmonary Heart Disease, Unspecified ___ I50.9 Congestive Heart Failure, Unspecified ___ I50.1 Left Heart Failure ___ I50.20 Unspecified systolic (congestive) heart failure ___ I50.21 Acute systolic (congestive) heart failure ___ I50.22 Chronic systolic (congestive) heart failure ___ I50.23 Acute on chronic systolic (congestive) heart failure
<h4>Sleep Related Codes</h4> <ul style="list-style-type: none"> ___ G47.30 Apnea, Unspecified ___ G47.30 Hypersomnia with Sleep Apnea, Unspecified ___ G47.30 Insomnia with Sleep Apnea, Unspecified ___ R09.02 Hypoxemia ___ G47.30 Sleep Apnea, Unspecified ___ G47.33 Sleep Apnea, Adult Pediatric 	<p style="text-align: center;">Other: _____</p> <p>* Date Patient Last Seen: ____ / ____ / ____</p>

My signature below certifies that the named patient above is having an awake / overnight oximetry to determine if the patient desaturates while sleeping, and / or qualifies for home nocturnal oxygen.

Physician Signature: _____ **Date:** _____