



Name of facility _____

Referral Contact _____

Phone: _____

Medical Center Respiratory

908 South 16th St Wilmington NC 28401
(910) 762-7007 (Phone) (910) 762-7062 (Fax)

Patient Name: _____
 Phone# _____
 Patient Home Address _____
 City, State, and Zip: _____
 Date of Birth: _____
 Patient Height: _____ Weight: _____ Sex: M F
 Primary Insurance: _____ Id#: _____
 Secondary Insurance: _____ Id# _____
 Emergency Contact & Phone #: _____

DIAGNOSIS: _____

EQUIPMENT NEEDED: (check items)

- | | |
|---|--|
| <input type="radio"/> Crutches | <input type="radio"/> Patient Lift |
| <input type="radio"/> Single Point Cane | <input type="radio"/> Trapeze Bar |
| <input type="radio"/> Quad Cane – Base Size: S or L | <input type="radio"/> Gel overlay |
| <input type="radio"/> Walker | <input type="radio"/> APP Mattress |
| <input type="radio"/> Walker with Wheels | (Alternating Pressure Pad) |
| <input type="radio"/> Rollator | <input type="radio"/> Bedside Commode |
| (Walker with wheels and seat) | <input type="radio"/> Drop arm Commode |
| <input type="radio"/> Wheelchair (Standard) | <input type="radio"/> Shower Chair |
| <input type="radio"/> Lightweight Wheelchair | (with or without back) |
| <input type="radio"/> Transport Wheelchair | <input type="radio"/> Tub Transfer Bench |
| <input type="radio"/> Elevating Leg Rest | <input type="radio"/> Diabetic Shoes |
| <input type="radio"/> Wheelchair Cushion | <input type="radio"/> Compression Stockings |
| <input type="radio"/> Scooter | <input type="radio"/> Nocturnal Oximetry |
| <input type="radio"/> Lift Chair | <input type="radio"/> Oxygen (See Section Below) |
| <input type="radio"/> Hospital Bed | <input type="radio"/> Other _____ |

O2 at _____ LPM via nasal cannula. Continuous or Nocturnal
 Pulse ox reading - _____ % on room air
 Obtained on _____ (date), while at: Rest, Exertion/ Exercise, or Sleeping
 Test performed by _____.
 Is patient mobile within their residence & require portable O2? YES NO
 Is patient able to tolerate a conserving device? YES NO
 If tested during exercise there are 3 readings that are required: O2 sat at rest _____, O2 sat during exercise
 _____ and O2 sat during exercise while on O2 to show improvement of hypoxemia _____.
 All 3 tests must be done at the same time.

Name of Referring Physician: _____ Length of Need: _____
 Physician's Signature: _____ Date: _____
 NPI _____ Please fax to Medical Center Respiratory at (910) 762-7062