

# Overnight Oximetry Order Form



Customer Support: (877) 337-7111  
Web: www.virtuox.net

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Prescription and Clinical Evaluation

**Patient Information:**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_  
First Last  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Insurance:**  Check here if self-pay

Primary Payer: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Secondary Payer: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone: \_\_\_\_\_

**Prescriber Information:**

Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
First Last  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Diagnostic Order:**

Overnight Oximetry / Awake Oximetry: Immediately and repeat in  30  60  90  Other \_\_\_\_\_ days to validate oxygen settings.

**Test Condition:**

Room Air  Oxygen: \_\_\_\_\_  APAP / CPAP / BIPAP: \_\_\_\_\_  Dental Device  Other: \_\_\_\_\_

**Diagnostic Codes:** (Check all ICD-10 codes that apply)

Respiratory Related Codes	Cardiac Related Codes
<input type="checkbox"/> C34.90 Malignant neoplasm of unspecified part of bronchus or lung	<input type="checkbox"/> I50.30 Unspecified diastolic (congestive) heart failure
<input type="checkbox"/> J44.9 Chronic obstructive pulmonary disease, unspecified	<input type="checkbox"/> I50.31 Acute diastolic (congestive) heart failure
<input type="checkbox"/> J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	<input type="checkbox"/> I50.32 Chronic diastolic (congestive) heart failure
<input type="checkbox"/> J43.9 Emphysema Unspecified	<input type="checkbox"/> I50.33 Acute on chronic diastolic (congestive) heart failure
<input type="checkbox"/> J45.20 Mild intermittent asthma, uncomplicated	<input type="checkbox"/> I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J45.22 Mild intermittent asthma with (acute) exacerbation	<input type="checkbox"/> I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J45.21 Mild intermittent asthma with (acute) exacerbation	<input type="checkbox"/> I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J45.909 Unspecified asthma, uncomplicated	<input type="checkbox"/> I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
<input type="checkbox"/> J47.9 Bronchiectasis, uncomplicated	<input type="checkbox"/> I50.9 Heart failure, unspecified
<input type="checkbox"/> J47.1 Bronchiectasis with (acute) exacerbation	<input type="checkbox"/> I01.8 Other acute rheumatic heart disease
<input type="checkbox"/> J84.10 Post Inflammatory Pulmonary Fibrosis	<input type="checkbox"/> I09.81 Rheumatic Heart Failure (congestive)
<input type="checkbox"/> J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia	<input type="checkbox"/> I27.0 Primary Pulmonary Hypertension
<input type="checkbox"/> R40.0 Somnolence	<input type="checkbox"/> I27.89 Other specified pulmonary heart disease
<input type="checkbox"/> R40.1 Stupor	<input type="checkbox"/> I27.9 Pulmonary Heart Disease, Unspecified
<input type="checkbox"/> R06.02 Shortness of Breath	<input type="checkbox"/> I50.9 Congestive Heart Failure, Unspecified
<input type="checkbox"/> R06.82 Tachypnea / Rapid Breathing	<input type="checkbox"/> I50.1 Left Heart Failure
<input type="checkbox"/> R06.2 Wheezing	<input type="checkbox"/> I50.20 Unspecified systolic (congestive) heart failure
<input type="checkbox"/> R06.00 Dyspnea	<input type="checkbox"/> I50.21 Acute systolic (congestive) heart failure
<input type="checkbox"/> R06.83 Snoring	<input type="checkbox"/> I50.22 Chronic systolic (congestive) heart failure
<input type="checkbox"/> R09.01 Asphyxia	<input type="checkbox"/> I50.23 Acute on chronic systolic (congestive) heart failure
<input type="checkbox"/> R09.02 Hypoxia / Hypoxemia	
	<b>Other:</b> _____
	<b>Date Patient Last Seen:</b> ____ / ____ / ____

**Prescriber Signature & Certification:** (Stamped dates / signatures not valid. Must be signed by Prescriber / PA / NP)  
 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.

**Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_\_