OXYENSURE PRESCRIPTION
(DETAILED WRITTEN ORDER)

Portable Oxygen Concentrator

Fax: (855) 492 9926
Phone: (858) 799 0085
Email: support@oxyensure.com

PATIENT GENERAL INFORMATION:

NOTE: Type all Patient information

First Name: _____ Last Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Date of Birth (mm/dd/yyyy): _____ Patient's Sex: _____ (M/F)

DETAILED DESCRIPTION OF ITEM ORDERED

NOTE: This section must only be completed by a qualified Physician

☐ **Portable Oxygen Concentrator (E1392)** Setting: ☐1 ☐2 ☐3 ☐4 **OR** Liters per minute _____ LPM

Frequency of use: Oxygen dose equivalent via nasal cannula_____hrs/day **OR** ☐ Continuous use

Est. Length of need: (# of months)_____ 1-99 (99 = lifetime) Date of order (mm/dd/yyyy)**:** _____

Primary Diagnosis:_____ Secondary Diagnosis*: _____

*If applicable

PHYSICIAN DETAILS:

First Name: _____ Last Name: _____ Physician NPI: _____

Phone: _____ Fax: _____

Address (Line 1): _____

Address (Line 2): _____

City: _____ State: _____Zip: _____

Physician Signature: _____ Date (mm/dd/yyyy): _____

(DISPENSE AS WRITTEN/DO NOT SUBSTITUTE)

I certify that I am the treating Physician and that the test, diagnosis and order information provided is accurate and complete, to the best of my knowledge.

Physician email address: _____

For your security, please do not send this document or any health records as email attachments. Oxyensure uses a secure platform to collect and complete the necessary documentation to support your patient. By providing us with an email address in the field above, we can send you a link to utilize this secure platform. The email address you provide will not be used by Oxyensure for marketing purposes.

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