



Specialized Pulse Oximetry Testing Service

1436 K Yankee Park Place
Dayton, Ohio 45458

In-Home Test Order Form

Phone(937)433-7768
Fax (937)433-7722

Patient Name _____

Street Address _____

City _____ State _____ Zip _____

Home Ph _____ Alt. Number _____

DOB ___/___/___ SEX M / F MARITAL STATUS S M W D SS# _____

DME Name _____ City _____ State _____

Phone _____ Fax _____

Medicare # _____ State _____ Primary Secondary

Medicaid # _____ State _____ Primary Secondary

Private # _____ Primary Secondary

Pvt Ins Name _____ Group # _____

Address _____ City _____

State _____ Zip _____ Phone _____

Insured Name _____ DOB _____

Relationship to patient Self Spouse Child Other _____

DIAGNOSIS (ICD-9) CODES _____

Oximetry Study on **ROOM AIR** CPAP _____ BiPAP _____

Includes Nocturnal, Rest and 6 Minute Walk on **ROOM AIR**

Oximetry Study on **OXYGEN** _____ LPM CPAP _____ BiPAP _____

Includes Nocturnal, Rest and 6 Minute Walk on **OXYGEN**

Rest and 6 minute walk on **ROOM AIR**

Rest and 6 minute walk on _____ **LPM OXYGEN**

Comments

Physician _____ NPI _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Fax (____) _____

Physician's Signature X _____ Date _____