



In Patient  
 Ambulatory/Out Patient

Urgent (Expedite)  
 Routine (Standard)

Member's Name:		Identification Number:	Date:
<input type="checkbox"/> Female <input type="checkbox"/> Male		Phone Number:	
Address:		Weight:	Height: Allergies:
Name Requesting Physician:		Referral Source: <input type="checkbox"/> Doctor's Office / <input type="checkbox"/> Hospital / <input type="checkbox"/> Skilled Nursing Facility / <input type="checkbox"/> Nursing Home	
Address:		Phone Number:	Fax Number:
ICD9 Codes:		Diagnosis:	
Referral To:		Phone Number:	Fax Number:
Discharge Pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility's Name:	Admission Date: / /	Discharge Date: / /
Home Nutrition: (Include Nutritional Evaluation, Calories and Special Diet)			
<input type="checkbox"/> Nutritional Evaluation <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Feeding Machine			
Name:		Rate:    Calories:    Intake Method:	
<b>DME: (Check Applicable Equipment)</b>			
<input type="checkbox"/> Walker Type: _____ <input type="checkbox"/> Wheelchair Type: _____ <input type="checkbox"/> Commode: _____ <input type="checkbox"/> Bed Type: _____ <input type="checkbox"/> Cane/Crutches: _____ <input type="checkbox"/> Seat Lift: _____ <input type="checkbox"/> Lifter: _____ <input type="checkbox"/> Grab Bars: _____ <input type="checkbox"/> Uro/Ostomy (size): _____ <input type="checkbox"/> Others: _____		<input type="checkbox"/> CPM/Degrees:    Flexion:    Extension: <input type="checkbox"/> Tens: <input type="checkbox"/> Leads _____ <input type="checkbox"/> Settings: _____ <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Suction Pump <input type="checkbox"/> Catheter _____ Size: _____	
<b>Blood Glucose Monitoring:</b>			
Testing Frequency:			
<input type="checkbox"/> Glucometer <input type="checkbox"/> QD <input type="checkbox"/> Lancets Device <input type="checkbox"/> BID <input type="checkbox"/> Strips <input type="checkbox"/> TID <input type="checkbox"/> Lancets <input type="checkbox"/> QID <input type="checkbox"/> Control Sol.		Diabetic: <input type="checkbox"/> Yes / <input type="checkbox"/> No    Insulin Dependand: <input type="checkbox"/> Yes / <input type="checkbox"/> No	
<b>Oxygen:</b>			
Type: <input type="checkbox"/> Gas <input type="checkbox"/> Liquid <input type="checkbox"/> Other: _____ Via: <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Ventury Mask _____ LPM: _____ / Hours: _____ / Days: _____ Tank Size: _____ / Quantity: _____ / <input type="checkbox"/> Concentrator <input type="checkbox"/> Oximetry: Sat O <sub>2</sub> _____ % <input type="checkbox"/> ABG's / PO <sub>2</sub> : _____ Length of Need: _____ O <sub>2</sub> : <input type="checkbox"/> Humidifier <input type="checkbox"/> Conserving Device		<input type="checkbox"/> C-PAP _____ <input type="checkbox"/> Bi-PAP _____ Ipap _____ Epap _____ Treatment: Frequency: _____ / Day    RR: _____ / min Ramps Setting: _____ Mask Size: _____    Head Gear: _____ Length of Need: _____ O <sub>2</sub> LPM: _____ <input type="checkbox"/> Humidifier <i>Include: Sleep study results/neuromuscular condition that justifies the use of equipment.</i>	
<input type="checkbox"/> Power Nebulizer <input type="checkbox"/> Duration 2 months or _____ <input type="checkbox"/> Albuterol 0.083%    Frequency: _____ <input type="checkbox"/> Ipratropium 0.2%    Frequency: _____ <input type="checkbox"/> Albuterol 3 mg/Ipratropium 0.5mg Frequency: _____ <input type="checkbox"/> Budesonide 0.25 or 0.5 mg Frequency: _____ <input type="checkbox"/> Nopenex 0.31 or 0.63 or 1.25 mg Frequency: _____		Provider Name: (Printed)  Signature / License Number:	
<b>Ventilators (Patient Evaluation Required):</b>		<b>PREAUTHORIZATION USE ONLY</b>	
<input type="checkbox"/> SLMV <input type="checkbox"/> CMV Specify: _____    I Vol: _____ Respiratory Rate: _____    FIO <sub>2</sub> %: _____ Pressure: _____    PEEP: _____ Other: _____		<input type="checkbox"/> Approved    Authorization Number: <input type="checkbox"/> Denied Determination Date: _____    Health Plan Coordinator Name: (Printed)	
<b>Platino &amp; Non Platino Members Forms Send To: Clinical Medical Services Fax: 787-622-3449</b>			