Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT
2100 Landmeier Rd | Elk Grove Village, IL 60007
PHONE: 800-834-4234 | FAX 847-931-7138

Written Order Prior to Delivery
ADULT SUCTION/AEROSOL

Patient Name	Insurance ID/Group
Address	Insurance Name Insurance Phone
Phone	Order Date
DOB	Height/Weight
Estimated Length of Need _____ (i.e. 99=lifetime)	ICD-10

RX: High Humidity Trach Collar (Supplemental oxygen requires desat results) - # hrs of use per day: _____

☐ room air	☐ 24% = 1 LPM	☐ 28% = 2 LPM
☐ 32% = 3 LPM	☐ 36% = 4 LPM	☐ 40% = 5 LPM

ADULT AEROSOL EQUIPMENT & SUPPLIES

QTY / MONTH		DESCRIPTION		HCPC	PART #
☐	1 ea/month	Rental	50PSI Compressor	E0565	PM15
☐	1 ea/month	Purchase	Corrugated tubing	A7010	1680
☐	2 ea/month	Purchase	Large volume nebulizer bottle (change q2 weeks)	A7007	1770
☐	2 ea/month	Purchase	Aerosol drainage bag (change q2 weeks)	A7012	001562
☐	1 ea/month	Purchase	Trach mask (allowable dependent on insurance)	A7525	T237
☐	1 ea/3 months	Purchase	Filter for Drive 50PSI	E1399	18450-filter

SUCTION EQUIPMENT & SUPPLIES

QTY / MONTH		DESCRIPTION		HCPC	PART #
☐	1 ea/month	Rental	Portable suction machine	E0600	7305PD
☐	90 ea/month	Purchase	Suction catheter size: ☐ 8fr (T182), ☐ 10fr (T183), ☐ 12fr (T184), ☐ 14fr (T185)	A4624	(check in description)
☐	2 ea/month	Purchase	Suction connective tubing	A7002	SUCTUBE72
☐	2 ea/month	Purchase	Suction canister & lid	A7000	IRC1140
☐	1 ea/month	Purchase	Filter/tubing kit for portable suction	A7013	AG5604
☐	1 ea/month	Purchase	Yankauer suction catheter (for oral cleansing)	A4628	T245

TRACHEOSTOMY SUPPLIES (If Medicare Insurance: Home Health agency is responsible)

QTY / MONTH		DESCRIPTION		HCPC	PART #
☐	1 ea/3 months	Purchase	Tracheostomy tube Manufacturer part #: _____	A7520	(check in description)
☐	30 ea/month	Purchase	Tracheostomy tube inner cannula Manufacturer part #: _____	A4623	(check in description)
☐	30 ea/month	Purchase	Trach tube holder (1 ea/day) ☐ Small: 597S ☐ Medium: 597M ☐ Large: 597L	A7526	(check in description)
☐	30 ea/month	Purchase	Trach cleaning kits: includes 4x4, 4x4 split, glove (1 ea/day)	A4629	T180
☐	30 ea/month	Purchase	HME Thermovents for ambulation (1 ea/day)	A7507	T134
STEP DOWN TRACH TUBE AND RESUSCITATION BAG MUST BE SENT HOME WITH PATIENT					

Please attach the following:

- Progress notes/face to face evaluation indicating patient need for prescribed equipment/supplies
- Test results
- Patient demographics sheet
- If supplemental oxygen is prescribed, please include WOPD for oxygen

In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature below certifies the medical need for these items for this patient. This form must be SIGNED and DATED by the prescribing Physician prior to dispensing supplies and medical equipment.

Physician Name		Physician NPI	
Physician Address		Physician Phone	
Physician Signature	No stamps please – not valid by law	Date	