

Respiratory and DME Plan of Care

[] New patient [] Existing

Patient Name _____ Date _____

PAP Therapy

[] Initial set up [] 24 Hour Phone Contact [] 2 week [] 1 Month [] 3 Months

Prescribed Therapy [] CPAP [] BI-LEVEL [] Auto Titrate [] BIPAP / ST [] BIPAP / SV

[] CPAP cm H2O _____ Ramp _____ [] Bi-Level [] Auto Titrate I / High _____ E / Low _____ B/R _____

PAP THERAPY

_____ C-PAP Serial # _____ Heater Serial # _____

[] Other Brand _____

[] Mask/size _____ [] Nasal pillow/size _____ Mask Type _____

OXYGEN AND TANKS

Oxygen: Rx: _____ Liters/Min Duration _____ Via _____ Cylinder E _____ M 6 _____ D _____ Other _____

[] Conserving Device [] Concentrator [] Home fill System _____ [] Back up System _____

NEBULIZER Make _____ Model _____ Serial # _____

[] Perm Neb kit [] Disposable Neb kit Times per day _____

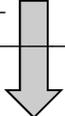
Home Equipment

[] Ambulatory Products [] Manual Wheelchair [] Bath & Safety [] Hospital Bed [] Seating products [] Bed Side Commode [] Rolling Walker

[] Standard Walker [] Hemi Walker [] TENS Unit [] Patient Lift [] Straight Cane [] [] OTHER _____

Device _____ Serial Number _____

[] Hospital Delivery [] Home Delivery [] Patient Picked up [] Doctor/Facility Delivery [] Via UPS/USPS



PROBLEMS/NEEDS/GOALS

- [] Understands Prescribed Therapy
[] Complies with Prescribed Therapy
[] Understands safe placement of equipment
[] Understands Safety Precautions
[] 24 Hour Phone # Evident
[] Written Instructions Available
[] Demonstrates/verbalizes proper use of equipment
[] Understands Infection Control (Cleaning)

Forms and Instructions; www.oxymed1.com

Follow up Required / Recommended

- [] Phone Follow up as needed
[] Visit Follow up
[] Mail
[] Return Symptoms
[] Mask Problems
[] Changes weight gain/ loss
[] Claustrophobia
[] Dryness

I have received the following

- [] Rights & Responsibilities
[] Service availability of OxyMed
[] Privacy Notice
[] Medicare Supplier Standards
[] AOB
[] Cleaning and maintenance
[] Infection Control tips
[] Follow up Instructions
[] Complaint Procedures
[] Warranty Policy

HOME ASSESSMENTS/ [] Fire Response [] Client Access/Environ. [] Electrical Safety/Requirements [] Emergency Response Plan

SAFETY NEEDS: (check all that apply) [] No assistance required [] General Safety Issues [] Able & Willing Caregiver [] Other: _____

FUNCTIONAL LIMITATIONS: [] none [] Incontinence [] Vision Impaired [] Hearing Impaired [] Speech Impaired [] Amb. Impaired [] Dyspnea

Complaint Protocol: If you are unhappy with the services provided by this company please call our compliance officer Rhonda Whidbee @256-638-7002. We will respond within 5 calendar days or sooner. In the event your complaint is not resolved to your satisfaction you can contact our accrediting organization The Compliance Team at www.thecomplianceteam.org or by calling 1-888-291-5353.

CAPPED RENTAL / ROUTINELY PURCHASED EQUIPMENT

Medicare defines the above listed equipment as a [] Routinely purchased item. Medicare purchases this item for you. [] Capped Rental Item, which means Medicare will rent the equipment for 13 months then the equipment becomes the property of the patient after all co-payments are met. [] Oxygen Capped Rental. Medicare rents your oxygen equipment for up to 36 months. For complete policy: www.oxymed1.com

For a complete listing of patient forms including The Privacy Notice, Capped Rental Policy, Patient Bill of Rights, Medicare Supplier Standards. Warranty Policy, Assignments of Benefits, can be found on our web site @ www.oxymed1.com. For hard copies of these forms, please call our office to request them. The forms will be mailed to you within 14 days or sooner.

I understand I have input into my plan of care and can change my plan of care at any time.

Patient Signature _____ Date _____

Company rep. _____ Date _____