



Date of Order: _____

Patient Name: _____ **DOB:** _____

Diagnosis Code(s) related to item(s) ordered: _____

Equipment:

Overnight Oximetry on Room Air

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____ **NPI:** _____

*****Please attach patient demographics*****

Fax back to: 320-231-4941

Thank you for making Lake Region Home Medical Supply part of your healthcare team. Please call 218-332-5920 if any questions.