


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
APNEA MONITOR / OXIMETER / OXYGEN (PEDIATRIC)**

Date of Last Provider Visit \_\_\_\_\_

<p><b>Supplier Name, Address, Telephone &amp; NSC#:</b></p> <div style="text-align: center;"><p><b>PROCARE</b> HOME MEDICAL</p></div> <p>4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770      Fax: (907) 274-0773 NSC#: 1267160001</p>	<p><b>Patient Name, Address, Telephone &amp; HIC#:</b></p> <p>(____) _____ - _____ HIC#: _____.</p> <p>Patient DOB: ____ / ____ / ____      Sex: ____ (M/F)</p>
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We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

**APNEA MONITOR / OXIMETER / OXYGEN & SUPPLIES:**

Date of Service: \_\_\_\_\_

Diagnosis and Code:

- Hypoxemia of Newborn (P84)
- Primary Apnea of Newborn (P28.3)
- Other Apnea of Newborn (P28.4)
- Bradycardia, Neonatal (P29.12)
- Other \_\_\_\_\_

Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life)

Patient Length: \_\_\_\_\_ ft. in.    Weight: \_\_\_\_\_ lbs.

Current Gestational Age (CGA): \_\_\_\_\_

**Apnea Monitor w Memory (E0619)**

\_\_\_\_\_ # hr/day

**Alarm Settings:**

Default settings are listed for reference.

- >42 weeks  
Apnea (20 sec): \_\_\_\_\_  
Bradycarida (60 BPM): \_\_\_\_\_  
Tachycardia (Off): \_\_\_\_\_

- <42 weeks  
Apnea (20 sec): \_\_\_\_\_  
Bradycarida (80 BPM): \_\_\_\_\_  
Tachycardia (Off): \_\_\_\_\_

**Event Recording:**

Apnea (16 sec): \_\_\_\_\_

Bradycardia (85 BPM): \_\_\_\_\_

**Monitor Downloads:**

- Every Two (2) Weeks
- Every Month
- When Memory is Full

**Supplies:**

- Electrodes (A4556)
- Belt, Foam (A9900)
- Leadwires (A4557)
- Conductive Gel (A4558)

**Oximeter - Continuous (E0445)**

\_\_\_\_\_ # hr/day

Alarm Settings:

Saturation (PO2): High \_\_\_\_\_ Low \_\_\_\_\_

Pulse: High \_\_\_\_\_ Low \_\_\_\_\_

**Oxygen**

Liter Flow: \_\_\_\_\_ Liters Per Minute (LPM)

Frequency:

- Continuous, or
- \_\_\_\_\_ hours per day
- Range of liter flow and use (i.e. "as needed up to 4 LPM." or "when short of breath,")

Route:

- Nasal Cannula     O2 Mask
- Other \_\_\_\_\_

**MEDICAL NECESSITY INFORMATION:**

**REQUIRED CRITERIA**

An apnea monitor is necessary for at least one (1) of the following:

- Infant with history of apparent life threatening event(s) that needs to be monitored for apnea and bradycardia so care giver(s) may intervene if necessary.
- Medically fragile infant on Oxygen needs home monitor so care givers can be aware of potential life-threatening event(s).
- Premature infant on caffeine needs monitored for apnea and bradycardia so care givers can be aware of life-threatening event(s).
- Other: \_\_\_\_\_

**PROVIDER CERTIFICATION:**

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Name

NPI: \_\_\_\_\_ Telephone: \_\_\_\_\_