Today's Date: ___/___/____ **Oxygen Patient Intake Form**

COMPLETE ALL SECTIONS, BLANKS AND SPACES

Do not include or attach Unnecessary PHI **Sign and date the form (electronic fill in is ok).**

Submit to: intake@lifegas.com **or** Fax **1. 888 738 2709** Attach a copy of the current, complete oxygen prescription.

Licensing regulations in Alabama, Delaware, Florida, Oklahoma, Texas and Virginia require that LifeGas have on file a copy of the current, complete and valid prescription in order to deliver oxygen directly to a patient.

Home Care Provider Information

Account Number:		Contact Phone Number:	
Company Name:		Contact Name:	
Contact email address :			

Patient Information

Type of Request:	☐ Add New Patient	☐ Change Existing Patient	☐ Stop Patient
Patient Name:		Year of Birth:	
Delivery Address, Apt #:			
Delivery City, State, Zip:			
Contact Phone Number:		Alternate number:	
Effective Date	enter date of start/setup; or the date to schedule the first fill or change, or to stop		
Frequency of refills	indicate how often deliveries are to be scheduled, i.e. monthly, weekly, will call, NA etc.		

☐ O2Shield Plan << Select Plan >>

Equipment Required for initial Delivery (indicate quantity of each): Cylinders Liquid Fill Only (no other equip)

I-Fill System Concentrator (stationary) Concentrator (portable) Liquid Base Liquid Portable

Liquid Oxygen Equipment to be filled is ☐ LifeGas owned or ☐ Customer owned

Comment (indicate other equipment or supplies to be delivered, or other instructions):

Patient Oxygen Prescription use requirements: (Complete for dose, duration and delivery device)

Dosage and Duration		Nasal Cannula	Face Mask - Type:	Trach Mask	CPAP/BiPAP Adapter	Other device:
____ LPM	Continuous	☐	☐ ____	☐	☐	☐ ____
____ LPM	PRN (as needed)	☐	☐ ____	☐	☐	☐ ____
____ LPM	With Sleep	☐	☐ ____	☐	☐	☐ ____
Other: ____		☐	☐ ____	☐	☐	☐ ____

Pulse dose (conserving device) at ____ setting.	Bubble humidifier to be used: ☐
Other:	

Rx Attached? ☐ Y ☐ N if yes, CLEARLY print full name of prescriber or NPI#:

Infection Control Precautions: ☐ Contact ☐ Air borne/Droplet ☐ Protective ☐ NA **if yes Dx?**

Print Name of Home Care Representative completing form	Signature of Home Care Representative completing form	**Date form sent to LifeGas**