Inogen Patient Referral Form

Please complete form & fax to Inogen Along With:

1. **Copy of Patient's Insurance Card(s)**
2. **Medical records with most recent qualifying oximetry (88%) or ABG (55mmhg) testing**
3. **ATTN: Geraldine Shepherd, RDM**

Call Geraldine Shepherd, RDM-Virginia at: (804) 420-8046 with any questions and THANKS for your Order!

PATIENT INFORMATION:

Patient Name: _____ SS#: _____

DOB: _____ Gender: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone# Home: (_____) _____ Phone# Alternate:

Emergency Contact: _____ Emergency Contact Phone#: _____

Please Note: It is only necessary to complete the below insurance section if NOT faxing a copy of patient's insurance cards

Primary Insurance: _____ Secondary Insurance: _____

Medicare ID#: _____ Secondary ID: _____

ORDERING PHYSICIAN:

Name: _____ Credentials: _____ ___

Address: _____ _____ _____ _____

Phone#: _____ Fax#: _____ NPI#: _____

Name of the person who is completing order if not physician: _____ Title: _____

PRESCRIPTION

Ordered Items: E1390 Inogen One System QTY: 1 & E1392 Inogen One Portable Component QTY: 1

Oxygen Continuous Flow setting: _____LPM via nasal cannula

Oxygen Pulse Dose setting: _____ via nasal cannula

Length of Need (# of Months):_____ (99=Lifetime)

Oxygen Use (circle one): Continuous / HS (hours of sleep) / Upon Exertion

Patient currently has oxygen equipment in the home? (circle one): Yes No

Is Patient Mobile within the home (circle one)? Yes No

Start Date (if other than signature date): _____

Prescriber Signature _____ Date: _____