# Prescription For Trach/Suction/Cool Mist/Supplies

**Ordering Physician:**

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

NPI: _____

St Lic: _____

_X_____

Signature Date

Start Date if different than Rx Date _____

**Patient Info:**

Name: _____

Address: _____

_____

Phone: _____

Alt Phone: _____

Insurance: _____

ID# _____

Ins Phone _____

DOB _____

Primary Language: ☐ English ☐ Spanish ☐ Both

Other Language_____

**Diagnosis Codes:** Trach : _____ Suction : _____

Duration of need is 99 unless otherwise notated. _____ Other duration

**Tracheostomy Supplies:**

☐ **Tracheostomy Care Kit A4629** (Ongoing Trach Care)
☐ Max Qty 1/day - up to 31/mo.

☐ **Oral/Trach Suction Device E0600**
☐ Stationary ☐ Portable
☐ Canister A7000 ☐ Suction tubing A7002
Qty ___/mo Qty ___/mo

☐ **Cool Mist Compressor 50 PSI E0565**

☐ **Tracheostomy Tube** ☐ ReUsable ☐ Disposable: Size: ☐ 4 ☐ 6 ☐ 8 ☐ 10
Tube Type: ☐ Non-Cuffed **A7520** 1/3 mos ☐ Cuffed **A7521** 1/3 mos

Brand _____ Model _____ Non-Fenestrated ☐ Fenestrated ☐ XLT ☐ Prox ☐ Distal

☐ **Lary Tube A7520** _____Brand _____ Type ☐ Non-Fenestrated ☐ Fenestrated

☐ **Inner Cannula A4623** (Check all that apply): ☐ ReUsable ☐ Disposable Size: ☐ 4 ☐ 6 ☐ 8 ☐ 10
__/day Max Qty 2/day - up to 62/mo. Brand _____ model _____

☐ **Tracheostomy Tube Collar A7526** 30/mo

☐ **Yankauer A4628** ☐ w/vent ☐ w/o vent
___ Qty, Medicare max 12/mo
___ Qty, Medi-Cal max 5/mo

☐ **Trach Suction Catheters A4624 3/day max**
Type _____ Size _____
Qty ____

☐ **Trach Adult Mask Disposable A7525 1/mo**
☐ **Neb Kit Disposable A7003 2/mo**
☐ **Neb Kit Non-Disposable A7005 1/6 mo** __
☐ **Corrugated Tubing 100ft A7010 1/ 2 mo**
☐ **Condensation Bag A7012 2/mo**
☐ **Large Volume Nebulizer A7007 2/mo**
☐ **Saline or Sterile Water for Suction/Cool Mist A4217 6/mo**
☐ **Passy Muir Speaking Valve L8501 1/3mo**

**Fax Completed Form to:**
**805-435-0432**

*Chart notes should indicate Dx(s) to support items prescribed in treatment plan. What, why, when, where, how, etc.*

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