LOTUS MEDIC AIR

SPECIALISING IN SLEEP APNEA THERAPY & HOME OXYGEN

"PURITY IS THE FORCE"

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MEDICAL AIDS WILL NOT GRANT AUTHORISATION WITHOUT ALL SUPPORTING DOCUMENTATION

Referring Doctor: _____ Practice No: _____

Tel: _____ Fax: _____

Email: _____

Signature: _____ Date: _____

Patient Details:

Title: _____ Initials: _____ Surname: _____

ID No: _____

Residential Address: _____

Tel No. _____ Cell No: _____

Medical Aid Name _____ Medical Aid No: _____

Main Member: _____ Dependent Code: _____

Next of Kin: _____ Tel No: _____

Prescription: **ICD 10 code:**

Oxygen LPM (1-10) ☐ Hrs/Day ☐ PAP Pressure(4-20) ☐

Stationery Concentrator	☐	OSA Test	☐
Portable Concentrator	☐	CPAP/APAP	☐
Cylinder Backup	☐	Bi-Level Machine	☐
Cylinder Portable	☐	Weight ☐	Height ☐

Suction Unit Electric ☐ or Battery ☐ Nebulizer ☐

Comments/Diagnosis

DOCUMENTS INCLUDED:

Arterial Blood Gas Report ☐

Lung Function report (Pre and Post Results) ☐

Chronic Forms ☐

_____

DOCTOR'S SIGNATURE