Fax | Oxygen Prescription

ranacaregroup.com/oxygen
Toll Free: 1-855-672-6262

To: RANA *Home Oxygen* RESPIRATORY CARE GROUP

Date: ___ / ___ / _____ (DD / MM / YYYY)

Fax: **306.522.1822**

Please start my patient on Home Oxygen NOW!
This prescription is for a complimentary home oxygen concentrator, valid for 30 days in the patient's home while their qualification for SAIL funding is being processed. Upon qualification, the concentrator will remain in the patient's home and RANA will provide the mobility oxygen equipment they should receive through the SAIL program. If the patient's SAIL application does not qualify for funding, RANA will remove the concentrator from the patient's home at no cost* after 30 days.
*damage caused by misuse or smoke will be charged to the patient for repair and cleaning

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Referring Physician Authorization (Please Print Information or Affix Clinic Label)

Name _____ **Clinic Name** _____

Phone _____ **Address** _____

Fax _____ _____

Patient Name: _____ **Birth Date:** ___ / ___ / _____ (DD / MM / YYYY)

Address: _____

_____ **Health Services Number:** _____

Phone: _____

℞

Oxygen Therapy:

☐ _____ LPM for _____ hours/day

☐ Maintain SpO_2 at ≥ _____%

Additional Notes:

Physician Signature: _____ **Date:** ___ / ___ / _____ (DD / MM / YYYY)

Physician Name (Print): _____

Doctor Prescriber Number: _____