

Fax | Oxygen Prescription

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



To:  *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

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

Name _____ Clinic Name _____
Phone _____ Address _____
Fax _____

Patient Name: _____ Birth Date: ___ / ___ / ___
Address: _____ Health Services Number: _____
Phone: _____

R_x **Oxygen Therapy:**
 _____ LPM for _____ hours/day
 Maintain SpO₂ at ≥ _____ %

Additional Notes:

Physician Signature: _____ Date: ___ / ___ / ___
Physician Name (Print): _____
Doctor Prescriber Number: _____

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