

IN TAKE-PRESCRIPTION

Patient Name: _____
Last First MI

Date: _____

Patient Address: _____
Street City/ State Zip Code

DOB: _____

Patient Phone Number: () _____ - _____ () _____ - _____ () _____ - _____
Home Work Cell

Diagnosis: OSA COPD Emphysema CHF Respiratory Failure ALS Other _____

NEW EQUIPMENT ORDERED:

- CPAP@:** _____ CmH₂O
- Auto-CPAP@:** _____ - _____ CmH₂O
- Bi-Level @:** _____ / _____ CmH₂O
- Auto Bi-Level EPAP Min@:** _____ IPAP Max@: _____ CmH₂O
- Bi-Level ST IPAP@:** _____ EPAP@: _____ Rate@: _____
- ASV** EPAPmin: _____ EPAPmax: _____ PSmin: _____ PSmax: _____ IT: _____
- Comfort Setting (A-Flex/EPR) _____ Ramp time _____ min
- Heated Humidifier Chinstrap
- All Supplies** (Mask, Mask Cushions, Headgear, Disposable/Non Disposable filters, Tubing and Humidifier Chamber) as needed.
- Please Fit Mask/Patient Comfort: _____
Or Please Specify Mask

Duration/Estimated Length of Need: _____ (12 months = 1 Year or 99 = Lifetime).

I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

ADDITIONAL SERVICES:

- Overnight Oximetry Study **PAP SUPPORT** (PAP/Mask Assistance) Repair (Inspection)
- Auto Titration (default setting): _____ Days or Weeks (**circle one**)
- Coordinate Sleep Study OXYGEN @: _____ Lpm. Bleed-in to PAP unit

Physician Name: _____

Address: _____
Street City/ State Zip Code

Telephone Number: () _____ - _____ Fax Number: () _____ - _____

Physician's Signature: _____