Order Form

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Start Date | Patient Name | Date of Birth | Male / Female

Primary ICD-10 | Secondary ICD-10 | Length of Need | Last Visit Date

PAP & Supplies *(PSG results required)*

CPAP ______ cmH2O   BiPAP ______/______ cmH2O   BiPAP ST ______/______   Rate ______

Heated Humidifier   Nasal Mask (1/3month)   Full Face Mask (1/3month)   Headgear (1/6month)

Nasal Pillows (2/month)   Nasal Cushions (2/month)   Full Face Cushion (1/month)   Chinstrap (1/6month)

Standard Tubing (1/3month)   Heated Tubing (1/3month)   Disposable Filter (2/month)

Non-disposable Filter (1/6month)   Water Chamber (1/6month)

Oxygen & Supplies *(copy of oximetry results required)*

Concentrator (Stationary) _____ LPM   Home-fill (Portable) _____ LPM   Conserving Device _____ Settings

VIA: Nasal Cannula   Mask   USAGE: Nighttime   24 Hours per day   Nighttime and PRN

Nebulizer & Supplies

Nebulizer Compressor   Disposable Neb Kit (2/month)   Reusable Neb Kit (1/6 month)

Neb Filter (2/month)   Medication Type: ____

Suction Machine & Supplies

Suction Machine   Canister (4/month)   Tubing (4/month)

Yankauer (2/month)   Catheter (90/month)

Clinical Assessment

Overnight Pulse Oximetry   Respiratory Assessment   Home Sleep Test   Afflovest Evaluation

Miscellaneous Home Medical Equipment *(describe below)*

Physician Name (first & last) | NPI | Physician Signature | Date

Facility Street Address | State | Zip | Phone

Please provide patient demographics, progress notes, and a copy of oximetry or sleep testing when applicable.