SLEEPCARE SOURCE

PRESCRIPTION WRITTEN OR VERBAL ORDER FOR O2/ CPAP/BIPAP/SUPPLIES ***Please Fax To: (916) 488-2727***

Patient Name: _____ DOB: _____ Date: _____

Address: _____

Home Phone: _____ Other: _____

Diagnosis: ☐OSA ☐COPD ☐CHF ☐ Respiratory Failure ☐ Other: _____

Oxygen ***Length of Need: _____ (12 months=1 year or 99=Lifetime)***

☐ Home Oxygen Concentrator at_____LPM via tubing & cannula
☐ Nocturnal (During Sleep)
☐ 24 Hour Oxygen (Pulsed Delivery via Portable Oxygen Concentrator) at setting of _____
☐ Nocturnal Oximetry Test ☐ Nebulizer (E0570) ☐ Nebulizer Kit (A7005) ☐ Nebulizer Mask(A7015) 1 Per 6 Months

CPAP and BIPAP 1 Per 5 Years 1 Per 6 Months ***Length of Need: _____ (12 months=1 year or 99=Lifetime)***

☐ CPAP:@_____cmH20 w/ Heated Humidifier
☐ Auto CPAP:_____-_____cmH20 w/Heated Humidifier
☐ Auto Bi-Level: IPAP Max:@_____cmH20 EPAP Min:@_____cmH20 Pressure support:_____ w/ Heated Humidifier
☐ Bi-Level S: IPAP@_____cmH20 EPAP@_____cmH20 ☐ Back Up Rate:_____ w/ Heated Humidifier
☐ Bi-Level ASV: EPAP Min:@_____cmH20 , Max:@_____cmH20 Pressure Support Min:@ _____cmH20, Max:@_____cmH20
Max Pressure:@_____cmH20 Rate_____BPM I-Time _____Sec. Bi-Flex_____ w/ Heated Humidifier
☐ BIPAP AVAPS: Target VT_____mL IPAP Max:@_____ EPAP Max:@_____ w/ Heated Humidifier
☐ Auto Titration (default setting to 4-20) w/ heated humidification X_____ days download data

CPAP and BIPAP Supplies: **** Please mark only one type of mask****

☐ Nasal Mask (A7034 x 1per 3 months, A7032 x 2per 1month, A7035 x 1 per 6 months) Specify Mask:_____
☐ Nasal Pillow Mask (A7034 x1 per 3 months, A7033 x 2 per 1 month, A7035 x 1 per 6 Months)
☐ Full Face Mask (A7030 x 1per 3 months, A7031 x 1per I month, A7035 x 1 per 6 months)
☐ Water Chamber (A7046 x 1 per 6 months) ☐ Tubing (A7037 or A4604 x1 per 3 months) ☐ Chin Strap(A7036 x 1 per 6 months
☐ Disp Filters (A7038 x 2 per 1 month) ☐ Non Disp Filters (A7039 x 1 per 6 months)

For AHI 5-14, please place a check mark if patient has any of the below diagnoses

☐Hypertension ☐ Pulmonary hypertension ☐ Impaired Cognition or mood disorders ☐ Snoring
☐Ischemic heart disease or history of stroke ☐ Cardiac Arrhythmias ☐ Chronic Fatigue
☐Excessive daytime sleepiness with a Epworth scale of 10 or greater

The patient has an absolute medical necessity for the item(s) prescribed above. I certify that the prescribed item(s) are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

Physician Name:_____

Address:_____

Telephone:_____ Fax:_____ NPI:_____

Physician Signature:_____ Date:_____