



PAP THERAPY ORDER FORM

(770) 449-6898 • fax (770) 449-3336

TO: _____

Name: _____ Facility: _____ FROM: _____ Phone: _____

PATIENT INFORMATION

NAME: _____ DOB: _____
PHONE: _____ ALT PHONE: _____ M F
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
SSN: _____ ALT CONTACT: _____ PHONE: _____

DIAGNOSIS

Obstructive sleep apnea (327.23) Central sleep apnea (327.21) COPD (496)
 Respiratory failure (518.83) Hypertension (401.0 - 401.9) Insomnia (327.00 - 327.09)
 History of stroke (434.91) Mood disorder (296.90 - 296.99) Ischemic heart disease (414 - 414.8)
 Other: _____ Excessive daytime sleepiness - Epworth score: _____

INSURANCE

Primary: _____ ID: _____ Group: _____
Secondary: _____ ID: _____ Group: _____

CPAP / APAP PHYSICIAN ORDERS

Auto titrating CPAP at _____ to _____ cm H₂O, heated humidifier and supplies for use while sleeping.
 Fixed pressure CPAP at _____ cm H₂O, heated humidifier and supplies for use while sleeping.
 Auto titrating CPAP at **4** to **20** cm H₂O, heated humidifier and supplies for seven days, download and replace auto titrating CPAP with fixed pressure CPAP set at 90th (Philips Respironics) or 95th (ResMed) percentile pressure for use while sleeping.

BILEVEL PHYSICIAN ORDERS

Auto titrating BiLevel with min EPAP of _____, max IPAP of _____ & pressure support of _____ cm H₂O, heated humidifier and supplies for use while sleeping.
 BiLevel with IPAP of _____ and EPAP of _____ cm H₂O, heated humidifier and supplies for use while sleeping.

OXYGEN AND OVERNIGHT OXIMETRY PHYSICIAN ORDERS

Bleed oxygen concentrator into PAP at _____ LPM for use while sleeping.
 Overnight oximetry on PAP at _____ cm H₂O. Overnight oximetry on room air.
 If SpO₂ ≤ 88% for ≥ five min dispense oxygen concentrator bleed into PAP at _____ LPM for use while sleeping.
 If SpO₂ ≤ 88% for ≥ five min dispense oxygen concentrator via nasal cannula at _____ LPM for use while sleeping.

OTHER PHYSICIAN ORDERS

Nasal mask. Full face mask. Disposable filters. Headgear. PAP tubing. Humidifier water chamber.
 Other: _____

FACE TO FACE EXAMS

Initial face-to-face exam conducted by: _____ On this date: _____
Follow-up face-to-face exam will be conducted by: _____ On this date: _____

STATEMENT OF MEDICAL NECESSITY

This equipment is medically necessary for this patient's well being. It is reasonable and necessary in reference to accepted standards of medical practice and it is not prescribed as a convenience. The estimated period of medical necessity is 99 months, or lifetime.

PRESCRIBING PHYSICIAN INFORMATION

PHYSICIAN NAME: _____ NPI: _____
PHYSICIAN SIGNATURE: X _____ DATE: X _____

Please include a copy of sleep study & initial face to face exam notes with order for new equipment.