Reliable RESPIRATORY

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Primary Insurance Name/ID: _____

Patient Address: _____

Referral Type (please select one): [ ] New [ ] Replacement [ ] Transfer (Supplies Only)

Date of Study: _____

AHI:_____ ESS: _____

If AHI is 5-14:

[ ]Excessive Daytime Sleepiness, Impaired, Cognition, Mood Disorders, or Insomnia

[ ]Hypertension, Ischemic Heart Disease, or Stroke

MACHINE ORDER:

Desired Machine Brand: (select one) Resmed | ReactHealth | SleepRes

[ ] CPAP (E0601): _____cmH2O

[ ] APAP (E0601): Min: _____cmH2O to Max: ____cmH2O

[ ] Bilevel (E0470): IPAP: _____cmH2O; EPAP _____cmH2O

[ ] Bilevel Auto (E0470): IPAP Max: _____cmH2O; EPAP Min: _____cmH2O; PS: _____cmH20

[ ] Bilevel ST (E0471): IPAP: _____cmH2O; EPAP: _____cmH2O; BR: _____BPM

[ ] ResMed Aircurve ASV (E0471):

ASV mode: EPAP : _____cmH2O PS Min: _____cmH2O to PS Max: _____cmH2O

ASV Auto: EPAP Min:_____cmH2O to EPAP Max:_____cmH2O; PS Min:_____cmH2O to PS Max:_____ cmH2O

Comfort Settings: *(optional)*

EPR: [ ] 1 [ ] 2 [ ] 3

KPAP: [ ] 1 [ ] 2 [ ] 3

Ramp time: _____ min(s) (Auto, Off-45 min)

Other:_____

Mask Preference : _____

[✓] Full Face Mask (A7030); 1 per 3 months & Full Face Mask Cushions (A7031); 1 per 1 month

[✓] Nasal Mask (A7034); 1 per 3 months & Nasal Mask Cushions (A7032); 2 per 1 month

[✓] Nasal Pillow Mask (A7034); 1 per 3 months & Nasal Pillows (A7033); 2 per 1 month

[✓] Mask to Fit; 1 per 3 months & Associated Cushions/Pillows; 2 per 1 month

Supplies used with the machine:

Heated Humidifier (E0562), Water Chamber (A7046); *1 per 6 months*, Headgear (A7035); *1 per 6 months*, Heated Tubing (A4604); *1 per 3 months*, Disposable Filters (A7038); *2 per 1 month*, Reusable Filters (A7039); *1 per 6 months*, Chinstrap (A7036); *1 per 6 months* Other: _____

Diagnosis:

[ ] G47.33 Obstructive Sleep Apnea [ ] G47.31 Central Sleep Apnea [ ] _____

Length of Need: Lifetime (unless otherwise specified) _____

Therapeutic Objective: To Treat OSA/CSA **Frequency of Use:** Nightly or While Napping

Ordering Physician:

Name: _____ **NPI**: _____

Address:_____ **Phone**:_____ **Fax**:_____

Signature: _____ **Date**: _____

CPAP/BiPAP orders require a Sleep Study & Office Notes for processing.

Provider: Reliable Respiratory **Phone: 781.551.3335** **Fax: 781.987.8206**