CPAP/BIPAP ORDER FORM

Please fax to (800) 676-3127

Patient Name ______________________ SS# ______________

Date of Birth ______________________ Home Phone ______________

Work Phone ______________________ Cell Phone ______________

Address ______________________ City/Zip Code ______________

Insurance ______________________ Authorization # ______________

Subscriber Name ______________________ Subscriber SS# ______________

Ordering Physician ______________________ Phone ____________ Fax ____________

Diagnosis ______________________ Height ________ Weight ________

Settings: CPAP ________ Cflex ________ EPR________ Auto-Titrating Device ________

BiPAP S or ST IPAP ________ EPAP ________ RR ________ Auto-BIPAP ________

Ramp Setting ________ Oxygen Setting ________

Download: Week ☐ Month ☐

Mask: Type: ______________________ Size: ________

Nasal Pillows: Type: ______________________ Size: ________

Other: ____

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Heated Humidifier ☐ Cool Humidifier ☐ Chin strap standard ☐ Chin strap deluxe ☐

CPAP/BIPAP Equipment Brand (if preferred) ______________________

COPY OF SLEEP STUDY REQUIRED.

Sleep Study attached ☐ **Yes** ☐ **No**

Comments:

Signature ______________________ **Date:** ______________

RespDept/adl/10-23-06