

Customer Name: _____		Date of Birth: _____	
Address: _____			
City: _____	State: _____	Zip: _____	
Phone: _____		Email: _____	
Diagnosis: <input type="checkbox"/> Obstructive Sleep Apnea (G47.33) <input type="checkbox"/> Central Sleep Apnea (G47.31) <input type="checkbox"/> Other _____			
Prescribed Pressure: _____		Length of Need: _____ (1-99, 99=Lifetime)	
Prescribing Physician: _____		NPI: _____	
Last Seen: _____		Next scheduled appointment: _____	

PAP **CPAP (E0601)** **BIPAP with backup (E0471)** **BIPAP without backup (E0470)**

Range:	<input type="checkbox"/> 4 to 20 cm	<input type="checkbox"/> Pressure: _____	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Change Pressure	<input type="checkbox"/> Decrease _____ cm	<input type="checkbox"/> Increase _____ cm
	<input type="checkbox"/> Other _____		
Humidifier:	<input type="checkbox"/> Heated Humidifier (E0562)		

Supplies

- | | |
|--|---|
| <input type="checkbox"/> Full Face Mask (A7030) | <input type="checkbox"/> Chin Strap (A7036) |
| <input type="checkbox"/> Face Mask Interface for full face replacement (A7031) | <input type="checkbox"/> Tubing (A7037) |
| <input type="checkbox"/> Replacement Cushion for nasal app (A7032) | <input type="checkbox"/> Heated Tubing (A4604) |
| <input type="checkbox"/> Replacement Pillows for nasal app (A7033) | <input type="checkbox"/> Oral Interface (A7044) |
| <input type="checkbox"/> Nasal Mask (A7034) | <input type="checkbox"/> Disposable Filters (A7038) |
| <input type="checkbox"/> Headgear (A7035) | <input type="checkbox"/> Non-Disposable Filters (A7039) |

Completed/Requested by (please print): _____	
Phone: _____	Fax: _____
Physician signature: _____	Date: _____