



Sleepwatchers, LLC

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DME (PAP) ORDER

Patient: _____ DOB: _____ Mobile #: _____

1.	MACHINE / MODE	SETTINGS	OPTIONS
<input type="checkbox"/>	CPAP (4 TO 20CM)	START/MIN EPAP PRESSURE: CM	<input type="checkbox"/> EXPIRATORY PRESSURE RELIEF: 1 2 3
<input type="checkbox"/>	AUTOMATIC CPAP (4 TO 20CM)	END/MAX IPAP PRESSURE: CM	<input type="checkbox"/> C-FLEX/BI-FLEX: 1 2 3
<input type="checkbox"/>	BILEVEL (3 TO 25CM)	<u>FOR BILEVEL MODES ONLY</u>	
<input type="checkbox"/>	AUTOMATIC BILEVEL (3 TO 25CM)	PRESSURE SUPPORT (0 TO 10): CM	<u>FOR BILEVEL MODES ONLY</u>
<input type="checkbox"/>	BILEVEL - COPD (3 TO 30CM)	<u>FOR BILEVEL-TIMED MODE ONLY</u>	<input type="checkbox"/> RISE TIME:
<input type="checkbox"/>	SERVO-VENTILATION	BACK UP RATE: _____ BPM	<input type="checkbox"/> MIN TIME FOR INHALE: MSEC
<input type="checkbox"/>	AUTOMATIC SERVO-VENTILATION	<u>FOR SERVO-VENTILATION ONLY</u>	<input type="checkbox"/> MAX TIME FOR INHALE: MSEC
		MIN PRESSURE SUPPORT (0 TO 6): CM	<input type="checkbox"/> TRIGGER: LOW MED HIGH
		MAX PRESSURE SUPPORT (5 TO 20): CM	<input type="checkbox"/> SENSITIVITY: LOW MED HIGH

2.	MASK		
<input type="checkbox"/>	NASAL PILLOWS	<input type="checkbox"/> NASAL TRIANGLE	<input type="checkbox"/> FULL FACE MASK
<input type="checkbox"/> Please specify Make Model & Size, if applicable:			

3.	ACCESSORIES		
<input type="checkbox"/>	HEATED HUMIDIFIER	<input type="checkbox"/> TUBING: STANDARD OR HEATED	<input type="checkbox"/> TUBING COVER
<input type="checkbox"/>	REMzzz's MASK LINERS	<input type="checkbox"/> CHINSTRAP	<input type="checkbox"/> GECKO PAD MASK CUSHION

4.	DIAGNOSIS: ICD & Description	
<input type="checkbox"/>	OBSTRUCTIVE SLEEP APNEA (G47.33)	<input type="checkbox"/> CHRONIC OBSTRUCTIVE PULMONARY DISEASE (J44.9)
<input type="checkbox"/>	COMPLEX SLEEP APNEA (G47.31, G47.33)	<input type="checkbox"/> CONGESTIVE HEART FAILURE (I50.2 __) SPECIFY EF: ____ %
<input type="checkbox"/> OTHER:		
LENGTH OF EQUIPMENT NEED: _____ MONTHS (99 = LIFETIME)		

5.	ORDERING PROVIDER	
NAME:	PHONE #:	
NPI #:	FAX #:	

PROVIDER SIGNATURE _____ DATE _____

PLEASE ATTACH ANY MEDICAL RECORDS THAT SUPPORT MEDICAL NECESSITY

FAX TO: (888) 608-0343