PAP Quick Script

Fax this form: **614-842-2467**

Patient Name: _____ Phone: _____ DOB: _____

Address: _____

Copy of Demographic information? ☐ *Yes* ☐ *No* *Copy of insurance information?* ☐ *Yes* ☐ *No*

Diagnosis: OSA ICD-9: G47.33 Length of need: 99

PAP Machine Setting:

- ☐ Auto Cpap at 4-20 cm H_2O/EPR – 3
- ☑ Heated Humidifier
- ☐ Overnight Oximetry (after 2 weeks on CPAP)
- ☐ Pulse Oximetry as needed to evaulate O_2 needs
- ☐ Other:

Accessories: Unless otherwise indicated below a Nasal Mask (up to 1 per 3 mo.) w/ replacement cushions or pillows (up to 2 per mo.) is prescribed

- ☑ Combination Oral/Nasal mask (up to 1 per 3 mo.) w/replacement oral cushion and pillow (up to 2 per mo.)
- ☑ Full Face Mask (up to 1 per 3 mo.) w/ replacement face mask interface (up to 1 per mo.)
- ☑ Headgear (up to 1 per 6 mo.)
- ☑ Tubing (up to 1 per 3 mo.)
- ☑ Water Chamber (up to 1 per 6 mo.)
- ☑ Chinstrap (up to 1 per 6 mo.)
- ☑ Filters (dispsable up to 2 per mo. and non-disposable up to 1 per 6 mo.)

Please attach copy of Baseline Polysomnography and Titration Polysomnography

By signing below, this validates the prescription above & indicates the patient has been informed that C-PAP Central will be conting them regarding this referral.

X _____

Physician's Handwritten Signature Date

Physician's Printed Name NPI# Phone