sleep insights CPAP

PAP ORDER FORM

Medical Directors
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www.sleepinsights.com

Last name	First name	MI
Phone	DOB	Gender

DX: ADULT OBSTRUCTIVE SLEEP APNEA (G47.33)

SELECT ONE:

AUTO CPAP and PAP SUPPLIES

____ Auto CPAP (settings 4-20 cm H20) with heated humidification

____ CPAP / BiPAP supplies (mask, filters, cushions tubing, headgear)

____ CPAP / BiPAP with heated humidification. Pressure setting: _____

____ ASV with heated humidification

EPAP:_____ Max PS: _____ Min PS: _____

PLEASE INCLUDE THE FOLLOWING:

☐ Demographic sheet & insurance info ☐ Recent diagnostic study

☐ Recent clinical note prior to diagnostic testing

FAX TO: (585) 385.6071

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name/address _____

_____

Phone/fax _____