



Sleepwatchers, PLLC

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DME (PAP) ORDER

Patient: _____ DOB: _____ Mobile #: _____

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

2.	MASK		
☐	NASAL PILLOWS	☐	NASAL TRIANGLE
☐	FULL FACE MASK		
☐ Please specify Make Model & Size, if applicable:			

3.	ACCESSORIES		
☐	HEATED HUMIDIFIER	☐	TUBING: STANDARD OR HEATED
☐	REMzzz's MASK LINERS	☐	CHINSTRAP
		☐	TUBING COVER
		☐	GECKO PAD MASK CUSHION

4.	DIAGNOSIS: ICD & Description	
☐	OBSTRUCTIVE SLEEP APNEA (G47.33)	☐ CHRONIC OBSTRUCTIVE PULMONARY DISEASE (J44.9)
☐	COMPLEX SLEEP APNEA (G47.31, G47.33)	☐ CONGESTIVE HEART FAILURE (I50.2 __) SPECIFY EF: ____ %
☐	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