Oxygen One, Inc.
The Home Respiratory & Sleep Specialists

PAP REFERRAL AND PRESCRIPTION FORM

Patient: ______________________________ **DOB:** ________________ **Sex:** ☐ **Male** ☐ **Female**

Daytime Phone: ____________________________ **SS#:** ____________________________

Physician: ____________________________ **Phone:** _____________ **Fax:** ______________

☐ **CPAP/AutoPAP/BiPAP with Heated Humidity**

Dx: ☐ **G47.33 OSA** ☐ **G47.31 CSA**

☐ **Other:**____________

☐ **CPAP (E0601):**________ cwp

☐ **AutoPAP (E0601/E1399):** Min.________cwp — Max.________cwp

☐ **VPAP/BiPAP S (E0470):** IPAP________cwp / EPAP________cwp

☐ **VPAP Auto/BiPAP Auto (E0470):** Max. IPAP_______ , Min. EPAP________ , PS ________

☐ **VPAP/BiPAP ST (E0471):** IPAP________cwp / EPAP________cwp, Back up rate ________

☐ **VPAP/BiPAP Auto SV (E0471):** Max. pressure________ , Min. EPAP ________ , Max. EPAP_______ ,

PS min. ________ , PS max. ________ , Rate________

☐ Other:____

☒ Patient to enroll in self-managed compliance monitoring application

☐ Download Compliance data in __________ weeks

Supplies: ☒ Mask - Full Face ☒ Mask - Nasal/Nasal Pillow ☒ Headgear ☒ Filters (permanent/disposable)

☒ Cushions ☒ Pillows ☒ Water Chamber ☒ Tubing (standard/climate line) ☒ Chin strap (as needed)

Comments: ____

____

Physician Signature **Date** **NPI#**

Please fax patient demographics, sleep studies, and clinical evaluation with this order

Phone: 262-521-2202 Fax: 262-521-2249

1900 Pewaukee Road Suite F Waukesha, WI 53188 www.OxygenOne.com