Sleep Therapy/Oxygen Therapy Order Form

Your Apria Representative ____________________

Branch location ____________________

Phone ____________________

FAX: 888-492-0010

REFERRAL SOURCE

Office name ____________________ Office contact name ____________________

Date ____________ Phone ____________________ Fax ____________________

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name ____________________ (Last) ____________________ (First) DOB ____________

Home phone ____________________ Mobile phone ____________________

Diagnosis ICD-9

- ☐ 327.23 Obstructive Sleep Apnea (Adult and Child)
- ☐ 327.21 Primary Central Sleep Apnea (Includes Complex Sleep Apnea)
- ☐ 786.04 Cheyne-Stokes Breathing Pattern
- ☐ Other ____________________

SLEEP THERAPY

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING SIGNS AND SYMPTOMS OF OSA, DIAGNOSTIC SLEEP STUDY AND TITRATION STUDY (IF APPLIABLE) FROM PATIENT'S CHART

Estimated length of need _______ months (99 = lifetime)

Date of the scheduled re-evaluation appointment with prescribing physician (no sooner than the 31st day and no later than the 91st day after setup): ____________

☐ Face-to-face evaluation/physician chart notes (for Medicare patients) Date ____________

☐ Completed sleep study Date ____________ AHI/RDI ____________

☐ Secondary diagnosis (if AHI/RDI is 5 – 14) ____________

☐ **CPAP** ____________ cm H_2O (4 – 20 cm H_2O) Ramp time _______ min(s) (OFF – 45 min)

☐ **Bi-level** Pressure: IPAP ____________ cm H_2O EPAP ____________ cm H_2O (4 – 25 cm)

☐ **Auto Adjusting Bi-level** Max IPAP _______ cm H_2O _______ Min EPAP _______ cm H_2O (4 – 25 cm)*

Ps min _______ cm H_2O (0 – 8 cm) Ps max _______ cm H_2O (Ps min -8 cm) *EPAP must be lower than IPAP

☐ Heated humidification

☐ Patient to choose mask to comfort, OR ☐ Mask type ____________ Mask size ☐ S ☐ M ☐ L

OXYGEN THERAPY — THIS INFORMATION IS NEEDED ONLY IF YOU ARE ORDERING OXYGEN

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING NEED FOR OXYGEN AND COPY OF QUALIFYING OXYGEN SATURATION TEST FROM PATIENT'S CHARTS

Estimated length of need _______ months (99 = lifetime) Bleed in oxygen at _______ LPM for use with PAP device

Qualifying Test Results for Oxygen: (required) Date of test ____________ Location of test ____________

☐ Stationary O_2 at _______ LPM ☐ Continuous ☐ Nocturnal

☐ Portable O_2 system

Route of delivery: ☐ Nasal cannula ☐ Via PAP ☐ Other ____________________

Please report qualifying SAT results: (required) SpO_2 % RA resting _______

Nocturnal: SpO_2 % ≤ 88% for _____ hours _____ minutes Lowest SpO_2 _______

Overnight Oximetry: _____ on PAP and room air OR _____ on PAP and oxygen @ _____ LPM completed _____ days after PAP setup

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the items prescribed.

Print prescriber's name ____________________ **NPI #** ____________

Prescriber signature ____________________ **Date** ____________

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