

PHYSICIAN INFORMATION



NAME: _____
ADDRESS: _____
PHONE: _____ FAX: _____
UPIN: _____ CONTACT: _____

PATIENT INFORMATION

NAME _____ D.O.B _____ S.S # _____ M _____ F _____
ADDRESS: _____ CITY: _____ ZIP: _____
PHONE# : _____

INSURANCE

MEDICARE HIC # _____ GROUP # _____
PRIVATE INSURANCE _____ MEMBER # _____

DIAGNOSIS

_____ SLEEP APNEA 780.53 _____ COPD 496. _____ CHF 428. _____ LUNG CA. 162.9
_____ EXCESSIVE DAYTIME SLEEPINES _____ HYPERTENSION 401.9, _____ ALS 335.20

OTHER DX: _____ PROGNOSIS: _____ LENGTH OF NEED (I.E 99) _____

OXYGEN THERAPY

HOME O2 AT _____ LPM _____ CONT _____ PRN
_____ W/ EXERCISE _____ WHILE SLEEPING

TEST RESULTS: DATE ____/____/____ PO2____ or % SAT _____ ON ROOM AIR

TESTING DONE: @ _____ REST _____ EXCERISE _____ SLEEP

_____ NOCTURNAL DESATURATION STUDY _____ on _____ lpm

OXYGEN SYSTEM

_____ HOMEFIL O2 SYSTEM _____ PORTABLE CONCENTRATOR
(ECLIPSE, INOGEN, FREE STYLE)
_____ STD. CONCENTRATOR & PORTABLE TANKS

CPAP / BILEVEL THERAPY

DEVICE PRODUCT

_____ CPAP
_____ AUTO CPAP
_____ BILEVEL
_____ ADAPT SV
PRESSURE: _____
AUTO PRESSURE
BILEVEL PRESSURE: _____

CPAP INTERFACES AND SUPPLIES

MASK : _____
SIZE: _____
_____ HEADGEAR
_____ TUBING
_____ CHINSTRAP
_____ HUMIDIFIER _____ HEATED
_____ DISPOSABLE FILTERS
_____ NON DISPOSALBE FILTERS

PHYSICAN SIGNATURE _____ DATE: _____

STATE LIC. # _____ NPI # _____ UPIN # _____