



PAP Device
Standard Written Order (SWO)

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 872-469-1673

Order Date: _____

Patient Name: _____

Home Phone: _____

Date of Birth: _____

Cell Phone: _____

Diagnosis: [] G47.33 Obstructive Sleep Apnea [] G47.31 Central Sleep Apnea [] G47.39 Other sleep apnea
[] G47.37 Central sleep apnea in conditions classified elsewhere [] Other: _____

PAP Device (select one and indicate settings)

Cpap (E0601) [] _____ cwp [] EPR / CFlex _____

Auto Cpap (E0601) [] _____ to _____ cwp

If a Bilevel is being ordered, has the cpap been tried and proven ineffective based on a therapeutic trial? Yes No (please circle)

Bilevel (E0470) [] IPAP _____ cwp, EPAP _____ cwp

Bilevel Auto (E0470) [] IPAP max. _____ cwp, EPAP min. _____ cwp. PS _____

Bilevel ST (E0471) [] IPAP _____ cwp, EPAP _____ cwp, Breathing Rate of _____ /minute.

Resmed VPAP Adapt (E0471) [] EEP _____ CWP PS min _____ PS max _____

Resmed VPAP Adapt Auto (E0471) [] EEP min _____ max _____ PS min _____ PS max _____

Respironics Bipap Auto SV (E0471) [] IPAP (range 4-25) _____ EPAP (range 4-25) _____ PS min _____ PS max _____
Backup Rate Set _____ or Auto _____

Humidifier - Select the humidifier chamber if humidification is ordered.

[] Heated (E0562)

[] Cool (E0561)

[] Repl Water Chamber for Humidifier (A7046) Dispense 1 Chamber every 6 months

Accessories

TUBING (select one)

[] Heated (A4604) Dispense 1 every 3 months
[] Standard (A7037) Dispense 1 every 3 months

FILTERS (select all that are required)

[] Disposable - (A7038) Dispense 2 per month
[] Non-Disposable (A7039) Dispense 1 every 6 months

[] Chin Strap (A7036) Dispense 1 every 6 months

Mask Options - Select Full, Nasal, Nasal Pillows OR Customer Choice for Mask

[] Allow Customer to Select Mask of Choice

Full Face Mask

(select all if a full face mask is ordered) [] Mask (A7030) Dispense 1 every 3 months

[] Repl Cushion (A7031) Dispense 1 per month

[] Headgear (A7035) Dispense 1 every 6 months

Nasal Mask

(select all if a nasal face mask is ordered) [] Mask (A7034) Dispense 1 every 3 months

[] Repl Cushion (A7032) Dispense 2 per month

[] Headgear (A7035) Dispense 1 every 6 months

Nasal Pillows

(select all if a nasal pillow mask is ordered) [] Mask (A7034) 1/3 months Dispense 1 every 3 months

[] Repl Pillows-Pair (A7033) Dispense 2 pair per month

[] Headgear (A7035) Dispense 1 every 6 months

If the patient is currently receiving oxygen therapy, please complete: Nocturnal Oxygen Bleed In _____ LPM

Physician Name: _____

NPI: _____

Physician Signature: _____

Date: _____

Physician Phone: _____

Fax: _____