BARNES HEALTHCARE SERVICES

PAP Therapy Prescription

Patient Information

Patient's Name: _____ MRN: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ Height: _____ Weight: _____

City: _____ State: _____ Zip: _____ Order Date: _____

Diagnosis

☐ Obstructive Sleep Apnea ☐ Central Sleep Apnea ☐ COPD

☐ Obesity Hypoventilation ☐ Other: _____

Oximetry Order

☐ Overnight Pulse Oximetry on PAP Device: _____ cm for PAP Therapy follow up.

CPAP - Bi-level

☐ Initial ☐ Renewal ☐ Revision Length of Need _____ months ☐ Lifetime

☐ E0601 CPAP @ _____cm H_2O ☐ Heated Humidity

☐ E0470 Bi-Level @ IPAP _____cm H_2O EPAP _____cm H_2O

☐ O_2 via N/C and / or PAP device @ ____ LPM to be used ☐ Continuously ☐ Nocturnally

☐ Conserving device to be used at _____ LPM, may increase LPM up to ____ for exercise / exertion

Bi-Level w/ Back up Rate (Respiratory Assist Device)

☐ E0471 Bi-Level ST ☐ E0471 Bi-Level AUTO SV ☐ E0471 Bi-Level AVAPS

Max IPAP _____ cm H_2O Min IPAP_____ cm H_2O

EPAP _____cm H_2O Rate _____ Volume _____

Additional Settings _____

☐ O_2 via N/C and / or PAP device @ _____ LPM to be used ☐ Continuously ☐ Nocturnally

☐ Conserving device to be used at _____ LPM, may increase LPM up to ____ for exercise / exertion

EQUIPMENT AND SUPPLIES

CPAP / BI-Level Supplies

☐ E0562 Humidity Heated
☐ E0561 Humidity non heated
☐ A4604 Tubing w/ Integrated Heating Element, 1/3mo
☐ A7027 Combination Oral/Nasal Mask 1/3mo
☐ A7028 Oral Cushion, 2/1mo
☐ A7029 Nasal Pillows, 2/mo
☐ A7030 Full Face Mask, 1/3mo
☐ A7031 Face Mask Interface, 1/1mo
☐ A7032 Cushion for Nasal Mask, 2/1mo
☐ A7033 Pillow on Nasal Cannula, 2/1mo
☐ A7034 Nasal Interface 1/3mo
☐ A7035 Headgear, 1/6mo
☐ A7036 Chinstrap 1/6mo
☐ A7037 Tubing 1/3mo
☐ A7038 Disposable Filter 2/1mo
☐ A7039 Non Disposable Filter 1/6mo
☐ A7044 Oral Interface 1/3mo
☐ A7046 Water Chamber 1/6mo

Verbal Orders

☐ VORB (VORB / Prescriber Name / BHCS Rep name / Credentials (Title) / Initials BHCS Rep)

☐ Order Clarification

Barnes Healthcare Services Representative Signature: _____ Date: _____

PRESCRIBER SIGNATURE

Prescriber Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

NPI: _____ License#: _____

Prescriber Signature: _____ Date: _____