CNS Respiratory	**PAP Prescription Referral Form**
3685 West 6200 South Taylorsville, Utah, 84129 Phone: (801) 973-0900 Fax: (801) 708-7866	

Date:	**Ordering Contact:**	**Phone #:**	**Fax #:**

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**	
Address:	**Apt. #:**	**City/State/Zip:**	
Alternate Contact/Relationship:		**Alt. Phone #:**	
Primary Insurance Plan:	**Ins. ID#:**		**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**		**Group #:**
Subscriber Name:	**Relationship:**		**Subs. DOB:**
Primary Care Physician (if diff.):		**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Length of Need: ☐ Life Time ☐ Other: | **ICD-10 Diagnosis Code(s):** ☐ G47.33 ☐ G47.31 ☐ Other:

☐ **New System Set-Up** ☐ **Settings Change** ☐ **Supplies Only**

☐ **Replacement PAP System** *Required - age of current machine*:_____ *Replacement reason:* _____

_____

☐ **CPAP**

Pressure Setting: (4-20 cm H_2O):_____cm H_2O

☐ **CPAP Auto**

Min. Pressure (4-20 cm H_2O): _____cm H_2O

Max. Pressure (4-20 cm H_2O): _____cm H_2O

☐ Re-Titrating only

☐ **BiPAP Auto**

EPAP Min. (*4–max. IPAP-3*):_____cm H_2O

IPAP Max. (*min. EPAP +3-25*):_____cm H_2O

Max. PS (3-8 cm H_2O):_____cm H_2O

☐ Re-Titrating only

☐ **BiPAP**

IPAP (4-25 cm H_2O):_____cm H_2O

EPAP (4-25 cm H_2O):_____cm H_2O

☐ **BiPAP S/T**

IPAP (4-30 cm H_2O):_____cm H_2O

EPAP (4-25 cm H_2O):_____cm H_2O

Rate (0-30):_____bpm

☐ **Bleed-in Oxygen @** Liters Per Minute (lpm) – requires titration and documentation of oxygen saturations

☐ Heated Humidifier, Heated or Standard Tubing (1 per 3 mos.), Humidifier chamber (1 per 6 mos.), Non-disposable filters (1 per 6 mos.), Disposable filters (2 per mo.)

Mask Options: (Choose One)

☐ **Nasal Interface** (1 per 3 mos.): Pillows or Cushion (2 per mo.), Headgear (1 per 6 mos.), Chinstrap (1 per 6 mos.)

☐ **Full Face** (1 per 3 mos.): Cushion (1 per mo.), Headgear (1 per 6 mos.)

☐ **Other**

Comments:

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN'S SIGNATURE AND DATE]

Physician Printed Name: **NPI#:**

Physician Signature: X **Date:**

Please attach all face to face documents & sleep study & fax to (801) 708-7866

THANK YOU FOR CHOOSING CNS RESPIRATORY SERVICES