GoodCare by CPCI

Home Medical Equipment and Oxygen
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Verification of BiPAP Order

BiPAP-S Order Form for Obstructive Sleep Apnea

Dear Doctor,

This form is submitted to you to verify the order received for bi-level (BiPAP) therapy for:

Patient_____ Initial Date of Service:_____

Renewal Date:_____

Diagnosis (ICD-9 Codes/Description):_____

_____

Was CPAP considered or tried?_____Yes_____No: Reason CPAP was not appropriate or not tolerated:_____

Are there correctable causes of this patient's sleep apnea? (e.g. weight, medication)☐Yes ☐No

If yes, describe:_____

The patient is:____ Symptomatic____Asymptomatic: re: Sleep Apnea

Impairments due to sleep apnea:_____

Sleep Study Performed: ____Yes____No; Date of Initial Test:_____Date of Titration Test:_____

Name of Sleep Lab:_____

(Polysomnogram/Sleep Study may be attached in lieu of completing Section below)

Initial Sleep Study:	**Titration Sleep Study:**
Combined A/H Index:_____	**Combined A/H Index_____**
Minimum sp02:_____	**Minimum sp02:_____**
Hours of Recorded Sleep:_____	**Hours of Recorded Sleep:_____**

Is Supplental Oxygen Ordered?____Yes_____No; 02 Flowrate with BiPAP:_____

This Patient now requires bi-level therapy (BiPAP) at: IPAP_____EPAP_____Ramp_____

Bi-Flex Option:____Yes____No; Humidifier:____Heated_____Unheated

Mask Specifications (if any)_____

Chinstrap:____Yes_____No

Length of Need:_____3 months_____6 months_____LIFETIME

Thank you very much for asking us to serve your patient.

Physician:_____NPI_____

Address:_____

Physician Signature:_____Date:_____

Mjf/BiPAP/s

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