GoodCare by CPCI

Home Medical Equipment and Oxygen
450 State Route 664 North • P.O. Box 997 • Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 •FAX: (740) 385-0474
242 W. 6th Ave.• Lancaster, Ohio 43130
Phone: (740) 652-9250 or 1-800-423-3625 •FAX: (740) 652-9253

Verification of CPAP Order
CPAP Order Form

Fax:_____
Total Pages:_____
Dear Doctor, Date:_____

Below is the information confirming your order for set-up of CPAP for:

Patient Name:_____HIC#_____
Address_____City_____State_____

The clinical information provided to us by you, Sleep Lab Hospital_____ included the following:

Date of Birth_____Height_____Weight_____
Diagnosis (including ICD-9 code)_____

Equipment (if specified):_____
CPAP Pressure_____ CFLEX: Yes No
Mask/Patient Interface: (if specified)_____
Humidifier: Yes No Heated Unheated; Chinstrap Yes No

*** * *NOTE: SLEEP STUDY RESULTS TO BE FAXED TO US PRIOR TO ACCEPTANCE OF REFERRAL * * ***

Pneumogram Results: Facility_____
Hours of Recorded Sleep_____
Diagnostic Study; Date_____ #Apneas:_____Obstructive _____Mixed _____Central
Apnea Index_____ Hypopnea Index _____ Total Index _____
Oxygen Saturation: Low _____
If AHI less than 15, please list symptoms, complications, secondary to sleep apnea (for Medicare patients)_____
_____

Titration Study: Date_____ #Apneas _____Obstructive _____Mixed _____Central
Apnea Index_____Hypopnea Index _____ Total Index _____
Level of CPAP _____ Sa02 with 02 and CPAP_____
Is Supplemental oxygen ordered with CPAP? Yes No; 02 Flow _____L/min.
Length of Need for CPAP Therapy: 3 Months 6 Months Lifetime

Thank you very much for asking us to serve your patient

Physician:_____NPI _____
Address:_____

Physician Signature:_____Date:_____

Mjf/cpap **Please Fax to:_____(740) 385-0474; _____(740) 652-9253**

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