PROVIDENCE HOME MEDICAL EQUIPMENT	
6410 NE Halsey, Suite 500 Portland, OR 97213 Phone: (503) 215-4663 Fax: (503) 215-4011	**Salem Location:** 2508 Pringle Road Salem, OR 97302 Phone: (503) 585-4027

PAP Prescription Referral Form

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):**

☐ **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

PAP System Includes: 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.)

☐ **Respiratory Therapist Mask Fitting**

Comments:

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

Physician Printed Name:	**NPI#:**
➡ **Physician Signature: X**	➡ **Date:**

Please attach supporting documentation & fax to 503-215-4011

THANK YOU FOR CHOOSING PROVIDENCE HOME SERVICES