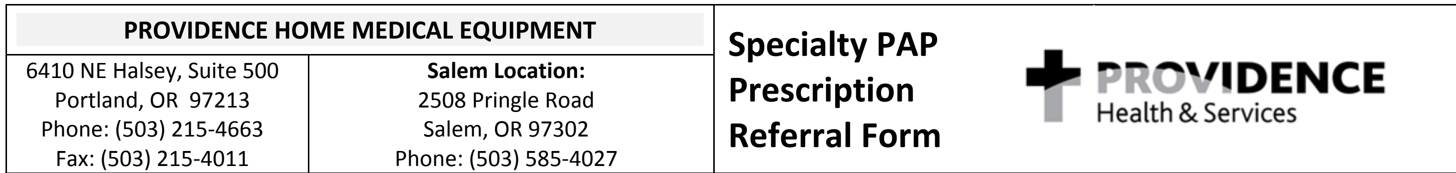

PROVIDENCE HOME MEDICAL EQUIPMENT

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

Specialty PAP Prescription Referral Form

PROVIDENCE Health & Services

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:**
Following Phys. (if diff. than Ordering):	**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Length of Need: ☒ Lifetime ☐ Other: **ICD-10 Diagnosis Code(s):**

RESMED PAP SETTINGS

☐ BiLevel ASV Mode

☐ Default mode settings		*Defaults:*
EPAP (4-15 cm H_2O):	_____ cm H_2O	*4 cm H_2O*
PS min. (0-6 cm H_2O):	_____ cm H_2O	*3 cm H_2O*
PS max. (5-20 cm H_2O):	_____ cm H_2O	*15 cm H_2O*
Ramp Time: (OFF – 45 min.)	_____ min.	
Backup rate: Automatic	15 bpm	

☐ Bi-Level ASV Auto Mode

☐ Default mode settings		*Defaults:*
EPAP min. (4-15 cm H_2O):	_____ cm H_2O	*4 cm H_2O*
EPAP max. (4-15 cm H_2O):	_____ cm H_2O	*15 cm H_2O*
PS min. (0-6 cm H_2O):	_____ cm H_2O	*3 cm H_2O*
PS max. (5-20 cm H_2O):	_____ cm H_2O	*15 cm H_2O*
Ramp Time: (OFF – 45 min.)	_____ min.	
Backup rate: Automatic	15 bpm	

☐ iVAPS Mode

Height: (44-100 in.):	_____ in.
Target Patient Rate (8-30):	_____ bpm
Target Va (1-30 L/min.):	_____L/min.
Vt (Tidal Volume):	_____ mL
Vt/kg:	_____ mL/kg
EPAP (3-20 cm H_2O):	_____ cm H_2O
PS min. (0-20 cm H_2O):	_____ cm H_2O
PS max. (5-27 cm H_2O):	_____ cm H_2O

RESPIRONICS PAP SETTINGS

☐ BiPAP Auto SV Advanced

EPAP min. (4-25 cm H_2O):	_____ cm H_2O
EPAP max. (4-25 cm H_2O):	_____ cm H_2O
PS min. (0-26 cm H_2O):	_____ cm H_2O
PS max. (0-26 cm H_2O):	_____ cm H_2O
Max. Pressure (4-30 cm H_2O):	_____ cm H_2O
Rate (auto, 4-30 cm H_2O, off):	_____ cm H_2O

☐ BiPAP AVAPS

IPAP min. (4-30 cm H_2O):	_____ cm H_2O
IPAP max. (4-30 cm H_2O):	_____ cm H_2O
EPAP (4-25 cm H_2O):	_____ cm H_2O
Target VT (200-1500):	_____ ml
Rate (0-30):	_____ bpm

☐ **Bleed-in Oxygen @** _____ Liters Per Minute (lpm)

☐ **Replacement PAP System** *Age of machine*: _______________

Replacement reason: ____

Mask Options: Choose One *or* ☐ **Respiratory Therapist Mask Fitting**

☐ **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.)

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.)

Comments:

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

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

Please attach sleep study and supporting documentation & fax to 503-215-4011