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LONG ISLAND CITY NY

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Home Medical Specialties, Inc.

Respiratory Products, Oxygen & Services

PAP THERAPY REFERRAL FORM

ORDER DATE: _____

PLEASE INCLUDE ALL RELEVANT RECORDS, NOTES & TEST RESULTS.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

State: _____ Zip: _____ Phone: _____ Height: _____ Weight: _____

Primary Insurance: _____ ID#: _____ Grp# _____

Secondary Insurance: _____ ID# _____ Grp# _____

Diagnosis: _____

Equipment Needed: ❑ CPAP ❑ BiPAP* ❑ ASV

❑ New setup ❑ Replacement Machine

Settings: _____ cmH2O

❑ Heated Humidification

❑ Supplemental Oxygen _____ lpm

Patient Interface: ❑ Fit for patient ❑ Specific: _____

❑ Full-Face mask	❑ Nasal Interface	❑ Filters
❑ Tubing	❑ Headgear	❑ Water Chamber
❑ Chin Strap	❑ Nasal Cushion	❑ Full Face Cushion

AHI from Polysomnagram:

Additional documented symptoms:

❑ History of stroke ❑ Excessive sleepiness ❑ Impaired Cognition

❑ Mood disorders ❑ Insomnia or hypertension ❑ Other: _____

Length of Need: _____

Face to Face with Physician (Please indicate dates)

Pre-Sleep Study: _____ Post-Sleep Study: _____

Physician Name: _____ Phone: _____

Address: _____ NPI#: _____

Contact Person: _____ Phone: _____ Fax: _____

I hereby acknowledge the accuracy of the information above and prescribe service.

Physician's Signuature: _____ Date: _____