SLEEP HEART
Getting to the heart of sleep!

Appointments: 703-348-7857
Fax: 703-444-4308
www.SleepHeart.com

CPAP / BiPAP Rx

Patient Name _____ DOB _____

Phone: Cell _____ Home _____

Prescribed Equipment (please check the appropriate boxes and enter the pressures)

☐ ___cm H_2O **CPAP** system including
- Flow Generator and filters and tubing
- Heated Humidifier and chamber
- Mask of nasal pillows/mask with chin strap or full-face mask
- Above and replacement supplies for 99 months (lifetime)
- CPAP therapist education and support program

☐ ___/___ cm H_2O **BiPAP** system including
- Flow Generator and filters and tubing
- Heated Humidifier and chamber
- Mask of nasal pillows/mask with chin strap or full-face mask
- Above and replacement supplies for 99 months (lifetime)
- CPAP therapist education and support program

Additional Comments (e.g. oxygen, backup rate): _____

_____

_____

Diagnosis: 327.23 Obstructive Sleep Apnea

ORDERING PROVIDER

I prescribe the above items and certify that these items are necessary for the care of the above patient's listed diagnosis for the specified duration.

Printed Name: _____ Phone: _____

Signature: _____ Date: _____

Please **fax to 877-511-3693** and the patient will be contacted to schedule an appointment.

Please Call 877-411-3693 to directly schedule an appointment.