AdventHealth | Respiratory and Equipment

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Detailed Written Order (PAP Therapy)

Patient Name:________________________________ Date of Birth: _____________ Diagnosis: ________________

Initial Date: ___________ Estimated Length of Need: (*Check One*) ☐ 99 Months (Lifetime) ☐ Or: ______________

PLEASE ATTACH: Patient Demographics, Signed Clinical Notes and Test Results (ABG, Oximetry, Sleep Study, etc.)

☐ **CPAP (E0601) w/ Heated Humidifier (E0562)**

Mode: ☐ Fixed

Pressure: _________________cm H2O (4-20)

Flex Setting (Pick One)

☐ C-Flex/EPR:_______________(Setting 1, 2, 3)

☐ C-Flex+: _______________(Setting 1, 2, 3)

Mode: ☐ Auto

Min __________________cm H2O (4-20)

Max __________________cm H2O (4-20)

A-Flex/EPR__________________(Setting 1, 2, 3)

Machine Type: _______________________________________

☐ **BiPAP (E0470) w/ Heated Humidifier (E0562)**

Mode: ☐ Fixed

Pressure: IPAP _________________cm H2O (4-25)

EPAP _________________cm H2O

☐ Bi-Flex:___________________(Setting 1, 2, 3)

☐ **Auto BiPAP (E0470) w/ Heated Humidifier (E0562)**

Choose one machine type below.

☐ **Phillips Respironics**

IPAP ______cm H2O (4-25)

EPAP ______cm H2O (4-25)

Min PS ______cm H2O (0-8)

Max PS_cm H2O (0-8)

☐ **Resmed**

IPAP_________cm H2O (4-25)

EPAP_________cm H2O (4-25)

PS___________cm H2O (0-10)

☐ **BiPAP ST (E0471) w/ Heated Humidifier (E0562)**

Pressure: IPAP___________________cm H2O (4-25)

EPAP___________________cm H2O (4-25)

BPM___________________cm H2O (0-30)

☐ **BiPAP AutoSV (E0471) w/ Heated Humidifier (E0562)**

Min EPAP _______________cm H2O (4-25)

Max EPAP _______________cm H2O (4-25)

Min PS _______________cm H2O (0-21)

Max PS _______________cm H2O (0-21)

Max Pressure_______________cm H2O (25)

Rate______________BPM (Auto, 4-30, Off)

☐ Bi-Flex:___________________(Setting 1, 2, 3)

MASK ORDER

*****Medicare*** *– Check either a full face mask* ***OR*** *a nasal mask.***

(Brand, Type, Size)

☐ Ex Sm ☐Sm ☐Med ☐Lg

☐ Nasal (A7034: 1 Every 3 Months): ______________________

With Cushions and Pillows (A7032 – A7033: 1 Every 3 Months)

~ OR ~

☐ Full Face (A7030: 1 Every 3 Months):____________________

With Cushions (A7031: 1 Every Month)

OTHER SUPPLIES

*****Medicare*** *– Check either heated* ***OR*** *standard tubing.***

☐ Heated Tubing (A4604: 1 Every 3 Months)

☐ Standard Tubing (A7037: 1 Every 3 Months)

☐ Chinstrap (A7036: 1 Every 6 Months)

☐ Disposable Filters (A7038: 2 Per Month)

☐ Headgear (A7035: 1 Every 6 Months)

☐ Non-Disposable Filters (A7039: 1 Every 6 Months)

☐ Water Chamber (A7046: 1 Every 6 Months)

ADDITIONAL SETTINGS

☐ Ramp Time:___________Minutes (0-45, 5min Increments, Auto)

☐ Heated Humidifier (E0562):_______________(Setting 1, 2, 3)

☐ Oxygen (Bleed-In)_______________Liters/Min

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, ordered the above mentioned items.

Physician Name (Print):____ Date: ___________________

Physician Signature:____ NPI: ____________________