FAIRWAY MEDICAL
Sleep Apnea Specialists

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939 S. 48th St. #210
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SLEEP THERAPY (PAP) + SUPPLIES PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Mobile Phone: _____ Other Phone: _____

Address: _____ Email: _____

Primary Insurance: _____ Policy Number: _____

Length of need: 99 Months_____

DIAGNOSIS / ICD-10

☐ Obstructive Sleep Apnea ☐ Central Sleep Apnea ☐ Other: _____

DEVICE TYPE

☐ CPAP/APAP ☐ BiPAP ☐ BiPAP Auto w/ Back up Rate ☐ ASV ☐ BiLevel ST w/ Back up Rate

Pressure Settings

_____ cmH2O

Humidifier(s)

☐ Heated Humidifier

CPAP Mask

☐ Patient Preference ☐ _____

Oxygen

☐ Home Oxygen Concentrator at _____ LPM

☐ Continuous (24 hrs.) or ☐ Nocturnal

Nebulizer

☐ Nebulizer Compressor System

CPAP/APAP/BiPAP SUPPLIES ONLY

☐ **Patient Preference**

Full Face Mask	Filter	Full Face Replacement Cushion
Nasal Mask	Disposable Filter	Nasal Mask Replacement Cushion
Nasal Pillows Mask	Headgear	Nasal Pillows Replacement Cushion
Tubing	Chin Strap	SD Card
Heated Tubing	Humidifier Chamber	

PHYSICIAN INFORMATION + SIGNATURE

Name: _____ NPI#_____ Phone # _____

Physician Signature: _____ Date: _____