

Standard Written Order (SWO)

Patient Information

Name:	DOB:	Gender:
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Diagnosis ***Indicate secondary diagnosis if AHI is less than 15***

☐ G47.33 OSA	☐ Hypertension	☐ History of Stroke	☐ Mood Disorder	☐ Excessive Daytime Sleepiness	AHI: _____ /hr.
☐ G47.37 CSA	☐ Ischemic Heart Disease	☐ Impaired Cognition	☐ Insomnia		LON 99 (99=Lifetime)

PAP Equipment

PAP Supplies

☐ CPAP (E0601 + E0562) Pressure: _____ cmH2O ☐ Auto CPAP (E0601 + E0562) Ramp Time: _____ Min CPAP: _____ cmH2O Flex Setting: _____ Max CPAP: _____ cmH2O Notes: _____	☒ All Standard Equipment - Standard Tubing (A7037) 1 per 3 months - Heated Tubing (A4604) 1 per 3 months - Disposable Filter (A7038) 2 per month - Non-Disposable Filter (A7039) 1 per 3 months - CPAP Headgear (A7035) 1 per 3 months - Humidifier Chamber (A7046) 1 per 6 months - Chinstrap (A7036) 1 per 6 months
☐ Bi-Level (E0470 + E0562) Pressure: EPAP: _____ cmH2O IPAP: _____ cmH2O Ramp Time: _____ ☐ Auto Bi-Level (E0470 + E0562) Flex Setting: _____ EPAP Min: _____ cmH2O Notes: _____ IPAP Max: _____ cmH2O PS: _____ cmH2O	☒ Mask: Fit to Comfort ☒ Nasal Mask (A7034) 1 per 3 months ☒ Nasal Cushion (A7032) 2 per month ☒ Nasal Pillows Mask (A7034) 1 per 3 months ☒ Nasal Pillows (A7033) 2 per month ☒ Full Face Mask (A7030) 1 per 3 months ☒ Full Face Cushion (A7031) 1 per month ☒ Combo Oral Mask (A7027) 1 per 3 months ☒ Combo Nasal Pillows (A7029) 2 per month ☒ Combo Oral Cushion (A7028) 1 per month
Respiratory Assist Devices (RAD) ☐ Bi-Level ST (E0471 + E0562) EPAP: _____ cmH2O Ramp Time: _____ IPAP: _____ cmH2O Flex Setting: _____ Backup Rate: _____ bpm Notes: _____ ☐ Auto Bi-Level ASV (E0471 + E0562) EPAP Min: _____ cmH2O Min PS: _____ cmH2O EPAP Max: _____ cmH2O Max PS: _____ cmH2O Backup rate: Auto	
☐ Specific Mask Interface Model/Size: _____ ☐ Other/Notes: _____	

Custom-Fabricated Oral Appliance

☐ Custom-fabricated, adjustable Mandibular Advancement Device (MAD) (E0486) Patient: ☐ is intolerant of PAP therapy, or ☐ has declined PAP due to a clinical issue.
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Provider Information

Name:	NPI#:
Address:	
Phone:	Fax:

Signature: _____ Date Signed: _____