MDS

**Medical Diagnostic Solutions**
*Sleep Testing and Interpretation Services*

954-401-7505 Tel
877-611-6844 Fax

**PRESCRIPTION**
**CPAP DEVICE • ACCESSORIES • SUPPLIES**

**PATIENT:** _____ **DOB**: _____ **Last 4 SSN:** _____ **Phone:** _____

**DOCTOR:** _____ **NPI:** _____ **Fax:** _____**Phone:** _____

□ **SLEEP TEST ATTACHED**

**TYPE OF SLEEP TEST** (Choose one)
□ Home Sleep Test (HST)
□ Attended Polysomnography (PSG)
□ Attended CPAP Titration (CPT)
**DATE OF SLEEP TEST** _____

**STATISTICS** (Chose one)
□ AHI ≥ 15
□ AHI ≥ 5 < 15 with (All that apply)
□ Excessive daytime sleepiness □ Impaired cognition □ Mood disorder
□ Insomnia □ Hypertension □ Ischemic heart disease □ History of stroke

**CPAP MACHINE Length of need** □ 99 years □ Otherwise Specified: ____

**TYPE OF DEVICE AND PRESSURE SETTINGS** (Choose One and complete)

□ **APAP** □ Pmin = 4 cm H2O Pmax = 16 cm H2O **or** □ Pmin = ___ cmH2O Pmax = ___ cm H2O E0601
□ **Fixed PAP** Pressure = ___ cmH2O E0601
□ **BiLevel (BiPAP)** Pins = ___ cmH2O Pexp = ___ cm H2O E0470
□ **Brand** □ Any □ Fisher & Paykel □ ResMed □ Respironics □ DeVilbiss □ Transcend □ Other _____

**COMFORT SETTINGS**
□ **EPR or C-Flex Comfort Level** □ 1 □ 2 □ 3

**ACCESSORIES**

□ **Heated Humidifier** E0562 and **Humidifier Chamber** A7046

**MASK (**Choose one from each row)
**Length of need:** □ 99 years □ Otherwise Specified: _____
**Refill** □ PRN □ Refill _____ (specify)
**Brand** □ Any □ Fisher & Paykel □ ResMed □ Respironics □ DeVilbiss □ Transcend □ Other _____
**Size** □ Petite □ Small □ Medium □ Large □ Standard □ Wide □ S/P □ Other _____
**Type** □ Nasal Pillow A7033 □ Nasal A7034 □ Full Face A7030 □ Hybrid A7027 □ Other _____

**SUPPLIES** (All that apply)
□ Headgear A7035 □ Chin Strap A7036 □ Tubing A7037 □ Tubing with Integrated Element A4604
□ Nasal Seals/Cushions/Flap A7032 □ Full Face Cushion/Flaps A7031 □ Hybrid Oral Cushion/Seals/Flaps A7028
□ Hybrid Nasal Pillows A7029 □ Disposable Filter A7038 □ Non-Disposable (HEPA) Filter A7039
□ Data Card A9279 □ Heat Moisture Exchanger □ Other □ Other □ Other

**Please note that prior to prescribing CPAP Medicare requires documentation in the patient's medical chart of a face to face visit with the patient to review the sleep test results.*

**Doctor Signature** _____ **Date**_____ **Dx: Obstructive Sleep Apnea ICD-9 Code: 327.23**

***Fax to: Medical Diagnostic Solutions***
***877- 611-6844***