AAPEX PHARMACY Rx

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Physician's Order
SLEEP APNEA

Date:_____

Patient Name:_____
First Middle Initial Last
Street Address:_____
City:_____ State: _____Zip _____
SSN:_____ Phone: _____
Patient ID Number (Medicare Number) _____
(Medicaid or Medicare Supplemental) _____
Patient Date of Birth _____ Sex: ☐Male ☐Female

1. EVALUATION:

☐ ***99214*** ***Sleep Evaluation at the sleep center.***

☐ ***95810*** ***Polysomnogram (Includes EEG, EOG, EMG, ECG, SaO2, airflow, respiratory effort, and leg movement.)***

☐ ***95811*** ***Polysomnogram with CPAP/BIPAP (includes the above monitored parameters with continuous positive airway pressure or Bi-level positive airway pressure).***

☐ ***95805*** ***Multiple Sleep Latency Test (MSLT)Multiple nap trials to assess sleepiness throughout the day.***

2. ORDER:

☐ **CPAP** ☐ **BIPAP** ☐ **OTHER**

3. Pressure: _____cm H_2O (4-20) Ramp Time: _____minutes 0-45(5 min. increments)

4. ⌠ Heated Humidifier ⌠ Pass Over Humidifier

Comments: _____
_____
_____

Prescribing Physician (Print Physician's Name): _____
Physician UPIN: _____DEA:_____ Date _____
Address:_____
City, State, Zip: _____
Physician's Phone _____
Physician's Fax: _____
Physician's Signature: _____