NEXUS HME CPAP PRESCRIPTION – FAX TO: 248-435-8602

Patient Name:_____ **Date of Birth:**_____

Diagnosis:

☐ Mild OSA	☐Moderate OSA	☐Severe OSA	☐ Hypoxemia	Other:
☐ Hypertension	☐ Coronary Heart Disease	☐ Excessive Daytime Sleepiness		Other:

☐	AUTO CPAP	Pressure:	Duration:	Notes:
☐	BIPAP	Pressure:	Duration:	☐ ST ☐ ASV

Mask:

☐	Small	☐	Full Face Mask q1 / month X 1Year PRN	A7030
☐	Medium	☐	Full Face Cushions q1 / month Xi Year PRN	A7031
☐	Large	☐	Nasal Mask ☐ Pillows Mask q1 / month x1 Year PRN	A7034
☐	Size to Fit	☐	Nasal Cushions q2 / month x1 Year PRN	A7032
		☐	Pillows Mask q2 / month x1 year PRN	A7033

Accessories:

☐	Head gear q1 /6 months qx1 year PRN	A7035	☐	Smart card	
☐	Chin strap q1 / 6 months x 1 year PRN	A7036	☐	Disposable filter q2 / month x 1 year PRN	A7038
☐	Tubing q1 / 3 months x 1 year PRN	A7037	☐	Climate tubing q1 / 3 months	A4604
☐	Substitution Permitted		☐	Water Chamber q1 / 6 months	A7046

Please Include:

1. **Patient Demographics**
2. **Face to face notes prior to sleep study**
3. **PSG / HST**
4. **Oxygen Titration**

Ordering Physician: _____ **NPI:**_____

Ordering Physician Signature: _____ **Date:** _____

7464 19 Mile Rd. Sterling Heights, MI 48314
T: 248-632-1700 F: 248-435-8602 | NexusMedicalEquipment.com