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

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

☐	CPAP	Pressure:	Duration:
☐	BIPAP	Pressure:	Duration:

Interface:

☐	Small	☐	Full face mask q1 / 3 month x 1 year PRN	A7030
☐	Medium	☐	Interface q1 / month	A7031
☐	Large	☐	Cushions q2 / month	A7032
☐	Size to Fit	☐	Nasal Pillows q1 / month x1 year PRN	A7033
		☐	Nasal Mask q1 / 3 months x1 year PRN	A7034
		☐	Other	

Accessories:

☐	Head gear q1 /6 months qx1 year PRN	A7035	☐	Smart card	
☐	Chin strap q1 / 6 months x 1 year PRN	A7036	☐	Non-disposable filters q1 / 6 mon x 1 year PRN	A7039
☐	Tubing q1 / 3 months x 1 year PRN	A7037	☐	Disposable filter q2 / month x 1 year PRN	A7038
☐	Substitution Permitted		☐	Climate tubing q1 / 3 months	A4604
☐	Other		☐	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:** _____

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