PM RESPIRATORY SERVICES, INC.

3306 SW 26TH AVE SUITE 402

OCALA, FL 34471

TELEPHONE: (352) 237-4545 FAX: (866)945-9458

CPAP ORDER FORM

PATIENT NAME:_____ DOB:_____DX:_____

EFFECTIVE DATE:_____

DME COMPANY: _____

CIRCLE ONE

AUTOPAP CPAP BIPAP

OTHER/BRAND: _____

PRESSURE SETTINGS:

_____ CM H20 PRESSURE CFLEX OF 1, 2, 3, NONE

HUMIDIFICATION: HEATED OXYGEN

YES/NO YES/NO _____ LPM BLEED INTO SYSTEM

MASK INTERFACE

NASAL _____ FULL FACE MASK_____ NASAL PILLOWS___

BRAND: _____ SIZE: SMALL, MEDIUM, LARGE

CHIN STRAP: YES/NO

LENGTH OF NEED: _____

ORDERING PHYSICIAN:

_____ _____ _____

PHYSICIAN NAME (PLEASE PRINT) PHYSICIAN SIGNATURE DATE