CPAPXCHANGE PRESCRIPTION FORM

Fax to 727-499-0901

PATIENT INFORMATION

Name	**Phone**
Date of Birth	**Email**

DIAGNOSIS

- ☐ Obstructive Sleep Apnea (327.23)
- ☐ Central Sleep Apnea (327.27)
- ☐ Mixed Sleep Apnea (780.57)
- ☐ COPD (496)
- ☐ Asthma (493)
- ☐ Other (Please Describe)

Notes

THERAPY PRESCRIBED (Indicate Multiple Items as Needed)

- ☐ Bongo RX (EPAP Nasal Therapy) for Mild to Moderate OSA
- ☐ eXciteOSA Therapy for Mild OSA
- ☐ CPAP E0601 **(Specify Pressure Setting in Notes)**
- ☐ APAP or Auto-CPAP E0601 (Pressure Range Optional)
- ☐ BiPAP, BiLevel or VPAP E0470 **(Specify iPAP & ePAP Setting in Notes)**
- ☐ Auto-BiLevel E0471 **(Specify Max iPAP, Min ePAP in Notes. Pressure Support Optional)**
- ☐ Pulse Dose (Portable) Oxygen Therapy **(Specify Pulse Dose Setting in Notes)**
- ☐ Continuous Flow Oxygen Therapy **(Specify Flow Setting in Notes)**
- ☐ Valved Holding Chamber
- ☐ Compressor Nebulizer Machine
- ☑ Supplies for the Above as Needed
- ☐ Other (Please Describe)

Settings & Notes

Length of Need (99 = Lifetime)

SUPPLIER

CPAPXCHANGE

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Nashua NH 03063 USA	**Tax ID**	38-3920635	**Web**	CPAPXchange.com

PRESCRIBING PHYSICIAN

Name	**Office Address**
License #	**City**
NPI #	**State / ZIP**
Phone	**Fax**
Signature	**Date**