Resmed

Patient name: _____
Address: _____
_____
Email: _____
Diagnosis: ☐ OSA ☐ Hypersomnia with sleep apnea
☐ Other: _____

Order date: _____
D.O.B.: _____
Phone number: _____
Diagnosis test date: _____
Duration of need*: ☐ 99 mo. ☐ Lifetime
☐ Other: _____
*Lifetime is default if left unchecked

Physician address: _____
_____

Physician phone number: _____
Physician fax number: _____

APAP™ Therapy

- ☐ **AirSense™ 11 AutoSet™** (w/integrated HumidAir™ humidifier)
- ☐ **AirSense 10 AutoSet** (w/integrated HumidAir humidifier)
- ☐ **AirMini™ AutoSet**

Therapy Modes (*select only one*)	**DEFAULT**
☐ **AutoSet mode**	
☐ Default mode settings	
Min. pressure:____cmH₂O (4-20cmH₂O)	**4** (**5** AirMini)
Max. pressure:____cmH₂O (4-20 cmH₂O)	**20**
Ramp time:____ min(s) (Auto, OFF-45 min.)	**AUTO**
EPR™: ☐ 1 ☐ 2 ☐ 3	
☐ **AutoSet for Her mode**	
☐ **CPAP mode**	
☐ Default mode settings	
☐ Custom settings	
Pressure:____cmH₂O (4-20 cmH₂O)	**10**
Ramp time:____ min(s) (Auto, OFF-45 min.)	**AUTO**
EPR: ☐ 1 ☐ 2 ☐ 3	

Therapy accessories

- ☐ ClimateLineAir™ heated tube
- ☐ SlimLine™ tube
- ☐ AirMini tube
- ☐ Combo mask oral cushion
- ☐ Combo mask nasal pillows
- ☐ Chinstrap
- ☐ HumidAir humidifier tub
- ☐ Nasal pillows cushions
- ☐ Full face cushions
- ☐ Filter, disposable
- ☐ Nasal cushions
- ☐ Headgear

Mask Interface

Full face masks

- ☐ AirFit™ F40
- ☐ AirFit F30i
- ☐ AirFit F30
- ☐ AirFit F20
- ☐ AirFit F20 for Her
- ☐ AirTouch™ F20
- ☐ AirTouch F20 for Her
- ☐ Fit to patient comfort

Nasal masks

- ☐ AirFit N30
- ☐ AirFit N30i
- ☐ AirFit N20
- ☐ AirFit N20 for Her
- ☐ AirTouch N20
- ☐ AirTouch N20 for Her
- ☐ AirTouch N30i
- ☐ Fit to patient comfort

Nasal pillows masks

- ☐ AirFit P30i
- ☐ AirFit P10
- ☐ AirFit P10 for Her
- ☐ Fit to patient comfort

Connected health

Wireless monitoring

- ☐ Add a physician to AirView™
- ☐ Invite patient to sign up for myAir™

Notes

Directions for use: ☐ Use at night while sleeping

☐ Dispense as written

Statement of medical necessity: The above patient has undergone a diagnostic evaluation. This evaluation has confirmed a positive diagnosis of sleep apnea. Positive airway pressure therapy is medically necessary and provides effective treatment of this disorder.

NPI #:_____ **Practitioner name:** _____

_____ _____
Practitioner signature (signature stamps and date stamps not permitted) *Signature date*

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