

PHYSICIAN ORDER FOR CLINICAL SERVICES / INTAKE FORM

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

*****Please include copies of insurance cards*****

Diagnosis: _____ ICD-9: _____ Length of Need: _____
(1-99, 99=lifetime)

Physician's Order:

- ApneaLink Overnight Study with Oximetry

- CPAP Therapy: _____ cmH2O
- BiLevel Therapy: IPAP: _____ cmH2O, EPAP: _____ cmH2O
- Auto CPAP Therapy: _____ to _____ cmH2O, Length of Study: _____
- Heated Humidity
- Supplies

- Nocturnal Oximetry
- Comprehensive Oximetry

- Nebulizer

- Oxygen: LPM: _____ Frequency: _____

- Other: _____

Physician Name: _____

Address: _____

UPIN: _____ NPI: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

*******Refer all Durable Medical Equipment to Sleep Therapy Solutions, LLC*******

*****Phone: 330-655-0630 / 866-858-9480 Fax: 330-655-0632*****
