

Home VPAP Adapt SV/O₂ Prescription

Patient's name: _____ DOB: _____ Date: _____

Ordering physician: _____ Phone: _____ Fax: _____

Polysomnography date: _____ AHI index: _____ O₂ nadir: _____ %

Diagnosis

Obstructive sleep apnea	327.23	<input type="checkbox"/>
Central sleep apnea	327.21	<input checked="" type="checkbox"/>
Insomnia	780.52	<input type="checkbox"/>
Periodic limb movement disorder	327.51	<input type="checkbox"/>
Hypoxia, Hypoxemia	799.0	<input type="checkbox"/>
Restless leg syndrome	333.94	<input type="checkbox"/>
Narcolepsy	347.00	<input type="checkbox"/>
Alveolar hypoventilation	780.51-1	<input type="checkbox"/>

Sleep study

Titration date: _____

Mask used during study: _____

Length of need: Lifetime Other: _____

Humidification: Yes No

Heated: Yes No

VPAP adapt SV setting: EEP: _____ cm/H₂O

Min PS: _____ cm/H₂O Max PS: _____ cm H₂O

Nocturnal oxygen: _____ lpm

Nocturnal pulse ox: In _____ weeks

Supplies: tubing, mask, headgear, misc. No substitution please

Physician Signature: _____

NOCTURNA Sleep Care

East: 9077 S. Pecos Road, Suite 3700
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West: 5191 W. Charleston Blvd, Suite 190
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