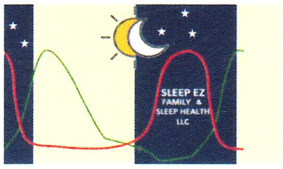

Sleep EZ Family and Sleep Health LLC

Farid Ahmed MD. (Sleep Medicine Physician)

Patient Name: _____ DOB: _____ Ht: _____ Wt: _____

Address: _____

Phone: _____ Mobile Phone: _____

Diagnosis: _____ Start Date: _____ Length of Need: ____ 99 months or _____

Sleep Therapy:

CPAP (E0601) w/ Heated Humidifier (E0562) Pressure @ _____ cm H2O, C-Flex or EPR @ 2-3 cm

Auto CPAP (E0601) w/ Heated Humidifier (E0562) Min. Pressure __cm H2O, Max. Pressure __ cm H2O, C-Flex or EPR @ 2-3 cm

BI-Level(BPAP) (E0470) w/ Heated Humidifier (E0562) IPAP __cm H2O, EPAP ___ cm H2O, BI -Flex or EPR @ 2-3 cm

Auto BI-Level(E0470) w/ Heated Humidifier(E0562) Max IPAP ___cm H2O, Min IPAP__cm H2O, Pressure Support__ cm H2O, BI-Flex or EPR @ 2-3 cm

BI-Level ST (E0471) w/ Heated Humidifier (E0562) IPAP ___cm H2O, EPAP ___ cm H2O, Rate: ___BPM, BI Flex or EPR @ 2-3cm

BI-Level ASV Auto (E0471) w/ Heated Humidifier (E0562) Min. EPAP Pressure ___cm H2O, Max EPAP Pressure___ cm H2O, Min. Pressure Support___cm H2O, Max. Pressure Support ___ cm H2O, Backup Rate Automatic, BI-Flex or EPR @ 2-3 cm

Oxygen (E1390) @ ___ LPM, nocturnal bled into PAP therapy

CHOOSE ONLY ONE MASK TYPE (FULL FACE, NASAL OR NASAL PILLOW)

Full Face Mask (A7030-1 per 3 months) with Headgear (A7035-1 per 6 month) and Replacement Facemask Cushion (A7031- 1 per month) OR

Nasal Mask/ Nasal Pillow Mask (A7034-1 per 3 month) with Headgear (A7035-1 per 6 months) and Replacement Nasal Cushion (A7032/ A7033-2 per month)

CPAP Supplies:

Tubing (A7037- 1 per 3 months) __ Heated Tubing (A4604- 1 per 3 months) __ Chinstrep (A7036-1 per 6 months)

Physician's specific instructions: _____

Oxygen Therapy:

O2 Concentrator (E1390) @ ____ LPM via NC ___O2 Portable Tank (E0431) ____ O2 Portable Homefill Unit (K0738) ___ Continuous ____Nocturnal ___ Conserving Device Regulator ____ Other___

PATIENT ASSESSMENT: Date of Test: _____

Saturation Levels (Fill in only those that apply): __At rest: ____ __Nocturnal_____

Walk Test: _____Rest: _____ ____Walk: _____ ____Walk with O2: _____

Attached: Face Sheet with patient's demographics, History and Physical, Sleep Study with documentation of expected benefit from the equipment ordered above, Copy of patient's insurance card.

Physician's signature: _____, NPI #: _____, Date_____

Farid Ahmed. MD

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