MERIT Sleep Technologies, Inc.

Phone: (888) 637-4848
Fax: (630) 652-7999

CPAP & BI-LEVEL PHYSICIAN ORDER FORM

Patient Name:____ Date of Birth:_____________

Address:____

City:____ State:______________ Zip:_____________

Phone: (Home)______________________ (Cell)_____________________ (Work)___________________

Please provide a copy of the following required patient information:

- **Diagnostic & CPAP Titration Interpretations** (only if sleep study not performed at MERIT)
- **Insurance/Medicare Card** (copy of front and back)

Diagnosis:____

CPAP/Bi-Level Therapy (Check all that apply):

☐ CPAP Therapy Pressure Setting: ___________ CmH_2O

☐ Bi-Level Therapy Pressure Setting: _____/______ IPAP EPAP

☐ Bi-Level ST Therapy Pressure Setting: _____/______ IPAP EPAP Rate :__________

☐ Auto-PAP Therapy Pressure Range: _____/______

☐ Oxygen with CPAP ___________ L/Min Other:______________________________

Length of Need:________________ ☐ Lifetime

Accessories (Required):

☐ CPAP Related Supplies (Mask, Tubing, Headgear)

☐ Heated Humidifier ☐ Cool Humidifier

Length of Need:________________ ☐ Lifetime

______________________________ ______________________________ ____________

Physician Name **Signature** **Date**

For questions, please call 888-637-4848 and ask for the Respiratory DME Supervisor