Sleep Therapy Prescription

Email Info@myreliefpain.com

PATIENT INFORMATION

Name	**Phone**
Date of Birth	**Email**

DIAGNOSIS

- O Obstructive Sleep Apnea (327.23)
- O Central Sleep Apnea (327.27)
- O Mixed Sleep Apnea (780.57)
- O Other (Please Describe)

Length of Need (99 = Lifetime)

Notes

EPAP THERAPY DETAILS (Indicate Multiple Items as Needed)

- O Provent Sleep Apnea Therapy (EPAP Nasal Device)

CPAP & BiLEVEL THERAPY DETAILS (Indicate Multiple Items as Needed)

- O CPAP E0601 **(Pressure Setting Required)**
- O APAP or Auto-CPAP E0601 (Pressure Range Optional)
- O BiPAP, BiLevel or VPAP E0470 **(iPAP & ePAP Pressure Setting Required)**
- O Auto-BiLevel E0471 (Max iPAP, Min ePAP, Pressure Support Settings Optional)
- O BiLevel ST E0471 **(iPAP, ePAP, Backup Rate Settings Required)**
- O BiPAP Auto SV / SV Advanced **(Specify Required Settings)**
- O VPAP Adapt SV **(Specify Required Settings)**
- O Supplies for the Above as Needed
- O Other (Please Describe)

Settings & Notes

SUPPLIER INFORMATION

Myreliefpain
14422 Shoreside Way Suite 110 PMB 134
Winter Garder Florida 34787

Toll Free 888-850-2375

Email Info@myreliefpain.com

Tax ID 46-1240847

PHYSICIAN INFORMATION

Name	**Address**
License #	**City**
Email	**State / ZIP**
Phone	**Fax**

Signature	**Date**