Medical Prescription Please Fax to SleepRestfully.com at (800) 540-5078

PATIENT INFORMATION

Name _____ Phone _____

Date of Birth _____ Email _____

DIAGNOSIS

⬭ Obstructive Sleep Apnea (327.23) Length of Need: ⬭ 99 Months ⬭ Other_____

⬭ Central Sleep Apnea (327.27) Notes:

⬭ Mixed Sleep Apnea (780.57) _____

⬭ COPD (496) ⬭ Other (Please Describe) _____

SLEEP THERAPY DETAILS (Check all that Apply)

⬭ CPAP Pressure _____ cmH2O Ramp _____

⬭ Auto CPAP Low _____ cmH2O High _____ cmH2O

⬭ BiLevel S/ST iPAP _____cmH20 ePAP _____cmH2O Backup Rate (ST only) _____

⬭ BiLevel Auto Max iPAP _____cmH2O Min ePAP _____cmH2O Pres Supt _____cmH2O

⬭ Heated Humidifier ⬭ CPAP Mask (Patient's Preference) Size: _____

⬭ Supplies for above as needed ⬭ Other _____

OXYGEN THERAPY DETAILS (Check all that Apply)

⬭ Portable Oxygen Concentrator (Pulse Dose) ⬭ Portable Oxygen Concentrator (Continuous/Pulse Dose)

⬭ Stationary Oxygen Concentrator _____LPM

⬭ Supplies for above as needed ⬭ Other _____

SUPPLIER INFORMATION

SleepRestfully.com (Sleep Restfully, Inc.) Toll Free: 866.923.2727

3100 Weslayan, Suite 373 Fax: 800.540.5078

Houston, Texas 77027 Email: sales@sleeprestfully.com

TX License: 0108334 Fed Tax ID: 26-3822802 NPI No: 1447572482

PHYSICIAN INFORMATION

Name _____ Address _____

License No. _____ City _____

NPI No _____ State/Zip _____

Telephone _____ Fax _____

PHYSICIAN SIGNATURE _____ **DATE** _____