PRESCRIPTION FORM

DirectHome MEDICAL

PATIENT INFORMATION

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

DIAGNOSIS

☐ Obstructive Sleep Apnea (327.23)	☐ COPD (496)	**Notes**
☐ Central Sleep Apnea (327.27)	☐ Asthma (493)	
☐ Mixed Sleep Apnea (780.57)	☐ Other (Please Describe)	

THERAPY PRESCRIBED (Indicate Multiple Items as Needed)

☐ Bongo RX (EPAP Nasal Therapy) for Mild to Moderate OSA	**Settings & Notes**
☐ eXciteOSA Therapy for Mild OSA	
☐ CPAP E0601 **(Specify Pressure Setting in Notes)**	
☐ APAP or Auto-CPAP E0601 (Pressure Range Optional)	
☐ BiPAP, BiLevel or VPAP E0470 **(Specify iPAP & ePAP Setting in Notes)**	
☐ Auto-BiLevel E0471 **(Specify Max iPAP, Min ePAP in Notes. Pressure Support Optional)**	
☐ Pulse Dose (Portable) Oxygen Therapy **(Specify Pulse Dose Setting in Notes)**	
☐ Continuous Flow Oxygen Therapy **(Specify Flow Setting in Notes)**	
☐ Valved Holding Chamber	
☐ Compressor Nebulizer Machine	
☑ Supplies for the Above as Needed	
☐ Other (Please Describe)	Length of Need (99 = Lifetime)

SUPPLIER

DirectHomeMedical	**Toll Free**	888-505-0212	**Email**	rx@directhmemedical.com
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Hudson NH 03051	**Tax ID**	80-0966280		

PRESCRIBING PHYSICIAN

Name	**Office Address**
License #	**City**
NPI #	**State / ZIP**
Phone	**Fax**
Signature	**Date**

FAX COMPLETED RX TO 603-386-6277