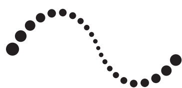

CRITICAL INFORMATION

Patient name: ____________________

Date of birth: ____________________

Prescribed duration of use: ☐ Lifetime ☐ 99 months

☐ Other: ____________________

Physician's diagnosis: ☐ Obstructive Sleep Apnea
☐ Hypersomnia with sleep apnea
☐ Other unspecified sleep apnea: ____________________

Patient Information

Patient Address: ____________________

Patient Phone number: ____________________

Patient Email: ____________________

Physician Information

Order date: ____________________

Physician Address: ____________________

Physician Phone: ____________________

Physician Fax: ____________________

Supplier: Expedite, LLC
600 Riverside Pkwy Ste 150, Lithia Springs, GA 30122
Fax: 855-492-9926 Phone: 833-968-2727

AirMini™

☐ AutoSet™ mode — **DEFAULT**

☐ AutoSet for Her™ mode

☐ Default settings

Min. pressure:_______cmH_2O (4–20 cmH_2O) — **5**
Max. pressure:_______cmH_2O (4–20 cmH_2O) — **20**

☐ Adjust to Patient Comfort

Response: ☐ Standard ☐ Soft — **Standard**
Ramp time: ☐ Auto ☐ Off
_______min(s) (5–45 min.) — **Auto**
Start pressure: _______cmH_2O (5–Min pressure)
EPR™: ☐ On ☐ Off — **On**
EPR Type: ☐ FT ☐ Ramp Only — **Ramp Only**
EPR Level: ☐ 1 ☐ 2 ☐ 3 — **1**

☐ CPAP mode

☐ Default settings

Set pressure:_______cmH_2O (4–20 cmH_2O) — **10**

☐ Adjust to Patient Comfort

Ramp time: ☐ Auto ☐ Off
_______min(s) (5–45 min.) — **Auto**
Start pressure: _______cmH_2O (5–Min pressure)
EPR: ☐ On ☐ Off — **On**
EPR Type: ☐ FT ☐ Ramp Only — **Ramp Only**
EPR Level: ☐ 1 ☐ 2 ☐ 3 — **1**

Mask Selection

☐ Fit to Patient Comfort

☐ Other: ______________ Size: ______________

Therapy Accessories

☐ All Related Supplies / Accessories

DO NOT SUBSTITUTE

Statement of medical necessity: The above patient has undergone a diagnostic evaluation. This evaluation has confirmed a positive diagnosis of sleep apnea. Positive airway pressure therapy is medically necessary and provides effective treatment for this disorder.

NPI#: ______________ **Practitioner name:** ____________________

Practitioner signature ____________________ *Signature date* ______________

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