Unity health network
Sleep Therapy

Unity Health Network, LLC Home Medical Equipment

Plan of Care/ Respiratory

PATIENT INFORMATION

Name: _____ DOB: ___/___/___ Sex: ☐ M ☐ F Date of Visit: ___/___/___
Address: _____
Telephone: (___) _____ Email Address: _____

CLINICAL INFORMATION

Diagnosis: _____ Sleep Center: _____
Referring Physician: _____

HOME ENVIRONMENT/SAFETY ☐ NA – NOT DELIVERED TO HOME

EQUIPMENT SETTINGS

CPAP/BIPAP:
Unit: _____ IPAP: _____
Pressure: _____ EPAP: _____
Mask SRE: _____ Usage: _____
Nasal Pillows/Seals: _____

Other:
_____
_____
_____
_____

ADDITIONAL INSTRUCTIONS

The following has been given and discussed to the patient/caregiver:

☐ Rights & Responsibilities ☐ Cleaning & Maintenance of equipment ☐ AOB signature
☐ Service availability of company ☐ Lease/Purchase Letter ☐ Equipment Instructions
☐ Privacy Notice ☐ Complaint process (how it is reviewed /resolved)
☐ Medicare Supplier Standards ☐ Warranty Information ☐ Return Demonstration

ADDITIONAL NOTES

NEED	GOAL	RESULTS

FOLLOW-UP PLAN

PATIENT RECEIVED INSTRUCTION ON COMPLIANCE REQUIREMENT & FOLLOW UP PROCESS (CHECK ALL BOXES IF/WHEN COMPLETE)

- FOLLOW-UP VISIT WITH ORDERING PHYSICIAN RECOMMENDED ☐ 31-90 FROM SETUP DATE
- FOLLOW-UP BY PHONE FROM THERAPIST & AS NEEDED ☐ 10, 30, & 90 DAYS FROM SETUP DATE

PATIENT ACKNOWLEDGEMENT

Assessed & Discussed the following with Patient/Caregiver: (√ box when completed)

- APPROPRIATE FOR HOME ☐Yes ☐No ☐Alert & Understands ☐Confused (caregiver instructed action taken)
- Returns Demonstration by patient DME item was checked and in good working order.

If no, complete _____

If patient is unable to sign, complete the following:

Patient or Auth Rep Signature: _____ Name of authorized person (print) _____

Employee Signature _____ Relationship _____ Why Pt Cannot: _____

Date: _____ Patient Signature: _____