



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:

Other:

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

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

<u>NEED</u>	<u>GOAL</u>	<u>RESULTS</u>
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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: _____