RESPSHOP / CPAPMAN
9215 151ST AVE NE, REDMOND WA 98052
Email: sales@respshop.com
Phone: 866-936-3754
Fax: 866-936-3730

Patient Name: _____ **Dr Fax #_____**
DOB_____
Address: _____
City _____ State _____ Zip_____
Phone _____

Our mutual patient is looking to obtain replacement CPAP equipment or supplies. They have authorized us to request their CPAP pressure information on their behalf from your office. Please complete this form and send it back to us at sales@respshop.com or by fax at 866-936-3730. Thank you.

ResMed AirCurve 10 VPAP-ST 37306/37307

ST-MODE IPAP_____ EPAP_____ RESP Rate____ TI MAX_____ TI MIN____ Rise Time_____

Trigger_____ Ramp Time _____

T-Mode IPAP_____ EPAP_____ RESP Rate_____ ITime (Optional) Rise Time _____
Ramp_____

S-MODE IPAP____ EPAP_____ TI Max____ TI Min___ Rise Time____ Trigger___ Ramp Time___

***Any Changes made after submitting requires new RX**

PHYSICIAN SIGNATURE: _____ DATE: / /
NPI#_____