RESPSHOP PRESCRIPTION FOR CPAP/BIPAP

Patient Information

NAME:___________________________________ ADDRESS:____

ZIP:_____________________ CITY:________________________ STATE:________________________________

PHONE:____ EMAIL:_______________________________________

ORDERING PHYSICIAN CONTACT INFORMATION

Machine Type and Corresponding Pressure

CPAP Pressure: __________cmH20 **AutoCpap Pressure:** MIN _________cmH20 MAX __________cmH20

BIPAP AUTO Dreamstation: ______MAX IPAP _______MIN EPAP _______MIN PS _______MAX PS

RESMED 10 VAUTO: ____IPAP _____ EPAP ____PS

Dreamstation BiPAP ST: _______IPAP _______EPAP ______RATE

Bipap VPAP ST/ASV: Rate____ IPAP____EPAP____ Ti____

Bipap VPAP ASV/ST: min PS_____ Max PS_____ Min EPAP_____ Max IPAP____

Bipap VPAP ST: Max PS_____ Min PS_____ EPAP______ RATE_____ VT______

BiPAP AVAPS: Ipap Max____ Ipap Min_____ Epap_____ VT______ Rate______ ITime______ Rise Time______

BiPAP autoSV: Min Epap___ Max EPAP_____ Min PS _____ Max PS ______ Max Pressure______ Rate______

SUPPLIES NECESSARY FOR USE OF PAP EQUIPMENT

______Full Face Mask ______ Nasal Mask _______Nasal Pillows _______Heated Humidifier ______Chin Strap

______ Tubing ______ Disposable Filters ________ Non-Disposable Filters ________ Heated Tubing

_______Humidifier Chamber _______ CPAP Pressure Valve _________O2 Enrichment Adaptor

DURATION OF USE

_____ Lifetime (99Months) ___________Years _____________Months

PHYSICIAN SIGNATURE: _______________________________________ **DATE:** ________________________

RESPSHOP

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