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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