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______________ PHONE_____________________
Address: ______________________________City ____________________ State ___ ZIP_______

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.

Machine Type

APAP: Pressure Min ________ Max________ cmH20 **OR** Default Setting _____

CPAP: __________ cmH20

BIPAP ResMed

ResMed 10 **Vauto**: Model 37211/ 37383 IPAP_____ EPAP_____ PS _____

BiPAP VPAP **ASV**: Model 37215 EPAP ______Min PS_____ Max PS______

ASV-Auto MIN Model 37215 Min EPAP_____ Max EPAP_____ Min PS _____ Max PS _____

Bipap VPAP S: Model 37306 IPAP___EPAP____TI Max___ TI Min______ RiseTime_____Trig___Cycle__

VPAP ST: IPAP____EPAP_____ RespRate____TiMax_____TiMin_____Rise Time____Trgr___Cycle____

VPAP T: IPAP____ Epap____ Resp Rate ____Ti____ Rise Time___

BiPAP ST-A Model 28210 Target VT____Rate____ EPAP____ PS Min___ PS Max___ Ramp Time ___

Oxygen

Supplemental Oxygen Flow Rate:________LPM Continuous or Pulse?_________

PHYSICIAN SIGNATURE: ____________________ **NPI**______________ **DATE: / /**

***Once submitted parameters cannot be changed without new signed RX**