CPAP PRESCRIPTION

Doctor Information

Doctor's GMC Number Or Surgery Stamp

Doctor's Name .....

Doctor's Phone Number .....

Doctor's Address .....

.....

.....

Doctor's Signature ..... Date .....

Patient Information

Patient's Name ..... Patient's Address .....

Patient's DOB ....

Patient's Phone No ....

Primary Diagnosis

❑ Obstructive Sleep Apnea ❑ Central Sleep Apnea ❑ Mixed Sleep Apnea

Medical Justification

What Is the (AHI) Apnea- Hypoapnea Index Score

❑ Mild (5-15/hr) ❑ Moderate (15-30/hr) ❑ Severe (30/h)

Please check for additional conditions within your medical notes for :-

❑ Excessive Daytime Sleepiness ❑ Impaired Cognition ❑ Mood Disorders ❑ Insomnia

❑ Hypertension ❑ Ischemic Heart Disease ❑ History Of Stroke

Sleep Study Information

❑ Polysomnogram has been completed (please copy and forward if available)

❑ Home sleep study diagnosis has been completed (please copy and forward if available)

CPAP Equipment

❑ CPAP Setting ____ cmH_2O ____

❑ Auto CPAP Low Setting ____ cmH_2O ____ High Setting ____ cmH_2O ____

❑ BiLevel UnitS/ST Setting ____ IPAP ____ EPAP ____ RATE ____

❑ Humidifier (heated) ❑ Humidifier (non-heated)

CPAP Mask

❑ Best Fit Mask OR SPECIFY ❑ Full Face Mask ❑ Nasal Mask ❑ Nasal Pillows Mask

CPAP Supplies

❑ All Necessary Equipment or Specify:

❑ Replacement Pillow ❑ Replacement Cushions ❑ Head Gear ❑ Tubing

❑ Filter (Disposable) ❑ Filter (Non Disposable) ❑ Humidifier Chamber ❑ Chin Strap

CONTACT PERSON _____ **PHONE** _____

Doctor Signature ..... **Date** .....

I certify that i am the treating physician identified on this form. I certify that the medical history on this form is true and complete to the best of my knowledge.