SLEEP APNEA PRESCRIPTION FORM

Date

PHN

DOB yyyy/mm/dd

Alt:

Address

Referring Physician

c.c. Report to

Tel

Fax

1 PATIENT INFORMATION

Name

Tel

Referring Physician

2 ASSESSMENT REQUESTED

☐ Level 3 Home Sleep Study
   - Includes measurement of respiratory effort, oximetry, AHI, snoring
   - Initiate CPAP/BiPAP treatment indefinitely, if indicated (includes post oximetry)

☐ Overnight Oximetry
   - Initiate CPAP/BiPAP treatment indefinitely, if indicated (includes post oximetry)

☐ CPAP/Auto CPAP for Sleep Apnea
   for ☐ mild ☐ moderate ☐ severe

☐ BiPAP therapy
   ☐ Hypoventilation syndrome
   ☐ COPD
   ☐ CPAP intolerant
   ☐ Hypercarbia

High Risk Patients

☐ hypertension
☐ MI
☐ stroke
☐ heart failure
☐ atrial fibrillation
☐ depression
☐ anxiety/mood disorder
☐ obesity
☐ diabetes
☐ retrognathia

3 SLEEP DISORDER SYMPTOMS

☐ loud snoring
☐ excessive daytime fatigue
☐ gasping/choking during sleep
☐ morning headaches
☐ frequent awakening/urination

Severity

AHI

DEI

Comments

Signature

MSP

Considered a valid prescription when signed by a physician

Better sleep through technology