

## BIPAP/CPAP Questionnaire

- Use this form when requesting purchase of a BIPAP/CPAP after the Member has completed rental trial.
- All fields must be filled out completely.

**Member Information:**

Name: \_\_\_\_\_ Member #: \_\_\_\_\_  
 Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Dx Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

**Prescriptions:**

BIPAP/CPAP Settings: \_\_\_\_\_ Hours Used at Last Visit: \_\_\_\_\_  
 Type of Equipment: \_\_\_\_\_ Current Hours Used: \_\_\_\_\_  
 Date of Set-up: \_\_\_\_\_ Total Hrs Used: \_\_\_ x \_\_\_ days a week

**Follow-Up Questionnaire:**

	Yes	No	
• Are you using BIPAP/CPAP every night?	<input type="checkbox"/>	<input type="checkbox"/>	_____ nights/week
• How many hours per night?	1 2 3 4 5 6 7 8	<input type="checkbox"/>	Other _____
• Have others noticed/complained about snoring?	<input type="checkbox"/>	<input type="checkbox"/>	
• Are you having any other sleep problems?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what: _____
• Are you sleeping better?	Worse	No Change	Better
• Do you feel tired during the day?	Never	Sometimes	Often
• When did you last see your physician?	Date (approximate): _____		

**Respiratory Therapist Question:**

	Yes	No	
• Do you recommend purchase of the unit?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, why: _____

**Comments: (Address goals of therapy, compliance, effectiveness, therapy problems and concerns, and plan for follow-up):** \_\_\_\_\_  
 \_\_\_\_\_

**Confidentiality Notice:**

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\_\_\_\_\_  
**Respiratory Therapist Name (print)**

\_\_\_\_\_  
**Respiratory Therapist Signature**

\_\_\_\_\_  
**Date of Visit**