

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? Have others noticed/complained about snoring?	1 2 3 4 5 6 7 8	Other _____
• Are you having any other sleep problems? Are you sleeping better?	<input type="checkbox"/> Worse	<input type="checkbox"/> If yes, what: _____ 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