



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
<input type="checkbox"/> | Other _____
<input type="checkbox"/> |
| • 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