ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

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?	☐	☐	_____nights/week
• How many hours per night?	1 2 3 4 5 6 7 8 Other _____		
Have others noticed/complained about snoring?	☐	☐	
• Are you having any other sleep problems?	☐	☐	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?	☐	☐	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