Clear Path
SLEEP AND RESPIRATORY

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PATIENT PRESCRIPTION FORM

Patient Information

Last Name: _____ **First Name:** _____

PHN: _____ **DOB (yyyy/mm/dd):** _____

Address: _____

Preferred Language: _____ **Gender:** _____

Phone: _____ **Email:** _____

Sleep Apnea / PAP Treatment Information (Accredited Home Sleep Apnea Testing Facility)

OSA Severity (Please Attach Diagnostic Results)

☐ Mild ☐ Moderate ☐ Severe **AHI (events per hour):** _____

Prescription:

☐ Initiate CPAP Therapy (5-15 cmH2O)

☐ BiPAP- no rate ☐ BiPAP ST ☐ BiPAP ASV

Indication: _____ **Mode/Setting:** _____

☐ Replacement CPAP/BiPAP and/or Supplies

☐ Other _____

Comments: _____

Respiratory Services (Accredited Pulmonary Function Facility)

☐ Spirometry testing (pre and post bronchodilator)

Reason for testing: _____

Prescribing Physician / Practitioner Information

Name: _____ **MSP #:** _____

Phone: _____ **Fax:** _____

CC Report To: _____ **Date:** _____

Signature: _____