



# RESPIRATORY THERAPY CARE CONSULTANTS

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

Clinical Information: \_\_\_\_\_

<input type="checkbox"/> Sleep Apnea Screening/Consultation		
<input type="checkbox"/> Overnight Oximetry		
<input type="checkbox"/> CPAP Therapy	Pressure Min _____ cmH <sub>2</sub> O Pressure Max _____ cmH <sub>2</sub> O	Ramp Pressure _____ cmH <sub>2</sub> O Ramp Time _____ minutes
<input type="checkbox"/> Auto-CPAP	Pressure Min _____ cmH <sub>2</sub> O Pressure Max _____ cmH <sub>2</sub> O	<input type="checkbox"/> Compliance Download
<input type="checkbox"/> Bipap Therapy	Pressure <sub>I</sub> Min _____ cmH <sub>2</sub> O Pressure <sub>I</sub> Max _____ cmH <sub>2</sub> O	Pressure <sub>E</sub> Min _____ cmH <sub>2</sub> O Pressure <sub>E</sub> Max _____ cmH <sub>2</sub> O
	<input type="checkbox"/> Humidification	<input type="checkbox"/> Heated <input type="checkbox"/> Passive
	<input type="checkbox"/> Interface	<input type="checkbox"/> Nasal Mask _____ <input type="checkbox"/> Nasal Pillows _____ <input type="checkbox"/> Other _____
Other: Please specify	_____	

Ordering Physicians Name

Physicians Signature

Date