RESOLVE
sleep health

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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

OSA Severity *(Please Attach Diagnostic Results)*:

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

Prescription:

☐ Initiate CPAP Therapy (5-15 cmH2O)

☐ BiPAP Therapy (For use by Sleep Specialists only)

Indication: _____ Mode/Setting: _____

☐ Replacement CPAP/BiPAP and/or Supplies

☐ Oral Appliance Therapy

☐ Cognitive Behavioural Therapy for Insomnia (CBT-I)

☐ Other:

Comments/Mallampati:

Prescribing Physician / Practitioner Information

Name:	**MSP#:**
Phone:	**Fax:**
CC Report To:	**CC Report To:**
Signature:	**Date:**

CoastalSleep · Clinical Sleep Solutions · OXYLIFE · CanSleep · ISLAND CPAP

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