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F: 0844 504 9494 / W: IntusHealthcare.eu

Confirmation of CPAP requirement

ATTENTION CLINICIAN: This patient would like to purchase CPAP equipment from Intus Healthcare. We do not currently have their prescription on file and require it before we can send the equipment to them. Please complete the details below and return it to Intus Healthcare by email to **contact@intushealthcare.eu** or by fax to **0844 504 9494**.

Patient Information:

Name: _____ Gender: ☐ Male ☐ Female

Address: _____

_____

_____

Postcode: _____ D.O.B.: _____/_____/_____

I confirm that the above patient requires the following PAP therapy equipment:

☐ **Fixed CPAP** Pressure Setting: _____ cmH_2O
Ramp time: _____ mins Ramp start pressure: _____ cmH_2O
Exhalation pressure relief (max = 3) ☐ OFF ☐ 1 ☐ 2 ☐ 3

☐ **Auto CPAP** Min Pressure: _____ cmH_2O Max Pressure: _____ cmH_2O
Ramp time: _____ mins Ramp start pressure: _____ cmH_2O
Exhalation pressure relief (max = 3) ☐ OFF ☐ 1 ☐ 2 ☐ 3

☐ **CPAP Mask** ☐ Full Face ☐ Nasal ☐ Other (please specify) _____

Clinician Information:

Name: _____

Title: _____

Hospital or Clinic: _____

Telephone: _____ Email: _____

Signature: _____