**Rx Request for Transcend® miniCPAP™ Purchase**

**ATTENTION PHYSICIAN:** This patient has purchased CPAP equipment from miniCPAP.com. We do not currently have their prescription on file and require it in order to ship the patient’s equipment to them. Please complete this form with your signature and return it by fax it to 651-204-0028. Thank you.

**Patient Information**

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

Address10422 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY, STATE, ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Diagnosis:

**Physician Information**

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

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CPAP equipment purchased (please indicate prescription settings for selected products):**

 CPAP Pressure setting:\_\_\_\_cmH2O

 Ramp time(0-45min): \_\_\_\_min Starting ramp pressure: \_\_\_\_cmH2O

 Pressure relief (max= 3): OFF 1 2 3

 APAP Min Pressure \_\_\_\_\_\_\_cmH2O Max Pressure \_\_\_\_\_\_\_cmH2O

 Ramp time(0-45min): \_\_\_\_min Starting ramp pressure: \_\_\_\_cmH2O

 Pressure relief (max= 3): OFF 1 2 3

 CPAP Mask

**Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**