Rx Request for Transcend CPAP Purchase

ATTENTION PHYSICIAN: This patient has purchased CPAP equipment from Transcend. 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 to 651-413-3477 or email at medicalrecords@mytranscend.com**. Thank you.

Patient Information

Name: _____

Address: _____

City, State Zip: _____

Phone: _____

DOB: _____

Diagnosis: G47.33 Obstructive Sleep Apnea

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

☐ APAP

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

Min Pressure _____cmH2O Max Pressure _____cmH2O

(If you don't know the settings, we will set the default 4-20cm, which will accommodate any CPAP user's needs, as this is an auto-titrating PAP.)

Ramp time (0-45min): ____min Starting ramp pressure: ____cmH2O

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

☐ CPAP Mask

Physician Signature:_____ **Date:**_____

Transcend ▪ 103 Osborne Road NE ▪ Fridley, MN 55432
Phone: 651-355-9006 Fax: 651-413-3477 http://mytranscend.com
medicalrecords@mytranscend.com