FAMILY 1st MEDICAL

Respiratory and Mobility Solutions

Head Office
8995 Commercial Street
New Minas, NS, B4N 3E3
Phone: (902) 681-0202
Fax: (902) 417-1558

Initial CPAP Prescription

Please fax to:

☐ *New Minas/ Head Office (902) 417-1558*	☐ *Yarmouth Office (902) 742-6444*	☐ *Sydney Office (902) 564-0919*
☐ *Antigonish Office (902) 863-8032*	☐ *Lower Sackville (902) 252-3170*	☐ *Amherst Office (902) 660-2051*

Name:	**DOB:**
Address:	**Phone:**

Obstructive Sleep Apnea Severity: ☐ Mild ☐ Moderate ☐ Severe		☐ Previous Sleep Study Included
Comorbidities:		
☐ None	☐ Diabetes	☐ CHF
☐ COPD	☐ Stroke/TIA	☐ Afib
☐ Hypertension	☐ Other _____	

* Please complete medical information section as this is used to properly triage patients.

Please complete an Auto CPAP Titration followed by Optimal CPAP Therapy for the above-mentioned patient for the treatment of Obstructive Sleep Apnea.

_____ Date

_____ Physician/Nurse Practitioner