



Respiratory and Mobility Solutions

Head Office

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

Replacement CPAP Prescription

Please fax to:

<input type="checkbox"/> <i>New Minas/ Head Office (902) 417-1558</i>	<input type="checkbox"/> <i>Yarmouth Office (902) 742-6444</i>	<input type="checkbox"/> <i>Sydney Office (902) 564-0919</i>
<input type="checkbox"/> <i>Antigonish Office (902) 863-8032</i>	<input type="checkbox"/> <i>Lower Sackville (902) 252-3170</i>	<input type="checkbox"/> <i>Amherst Office (902) 660-2051</i>

Name:	DOB:
Address:	Phone:

Obstructive Sleep Apnea Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Previous Sleep Study Included	
Comorbidities:		
<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	<input type="checkbox"/> CHF
<input type="checkbox"/> COPD	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Afib
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other _____	

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

Please provide a replacement CPAP unit for the above-mentioned patient for the treatment of Obstructive Sleep Apnea.

Date

Physician/Nurse Practitioner

