

miniCPAP.com
2355 Fairview Ave, #123
Roseville, MN 55113
Fax: 651-204-0028
Office: 800-678-9695

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: _____

Address: _____

CITY, STATE, ZIP: _____

Phone: _____

Diagnosis: 327.23 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
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: _____