Trial ☐

# BiPAP Setup Notification

**To:** _____ **Date:**

**Attn:** _____

## Patient Information

Name: Health Card:

Tel: DOB(d.m.y):

## Therapeutic Information

Date of setup: Machine Chosen:

BiPAP Max IPAP: Interface Chosen:

BiPAP Min EPAP: Ramp Settings:

Pressure Support:

Notes:

## Education (Y/N)

Obstructive Sleep Apnea Syndrome (OSA): ☑
BiPAP Therapy: ☑
Signs and Symptoms of OSA: ☑
Benefits and Risks of BiPAP Therapy: ☑
Equipment Use and Maintenance: ☑
Equipment Selection: ☑
ADP and Other Funding Sources: ☑

## Extensive Follow-Up Schedule

All patients will be follow-up by a Registered Respiratory Therapist/RN at:
**One Week, One Month, Three Months, and Annually**
Sincerely,