Trial ☐

AutoPAP Setup Notification

To: _____ **Date:**

Attn: _____

Patient Information

Name: Health Card:

Tel: DOB(d.m.y):

Therapeutic Information

Date of setup: Machine Chosen:

Prescription: Interface Chosen:

Machine pressure: Ramp Settings:

Notes:

Education (Y/N)

Obstructive Sleep Apnea Syndrome (OSA): ☑
CPAP Therapy: ☑
Signs and Symptoms of OSA: ☑
Benefits and Risks of CPAP 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,