archer
SLEEP CARE

Phone/Fax: 778-375-1975
Email: info@archersleepcare.com
Website: archersleepcare.com

Patient Prescription Form

Patient Information

Last Name:	First Name:
PHN:	DOB (yyyy/mm/dd):
Address:	
Gender:	
Phone:	Email:

Sleep Apnea / PAP Treatment Information

OSA Severity *(Please Attach Diagnostic Results)*:

☐ Mild ☐ Moderate ☐ Severe AHI (events per hour):

Prescription:

- ☐ Initiate CPAP Therapy (5-15 cmH2O)
- ☐ Replacement CPAP/BiPAP and/or Supplies
- ☐ Follow Existing or Intolerant CPAP Users (Titrate pressure to keep AHI <5)
- ☐ BiPAP Therapy Mode/Setting: _____
- ☐ Sleep Medicine Consultation _____
- ☐ Positional Therapy

Special Instructions:

Prescribing Physician / Practitioner Information

Name:	MSP#:
Phone:	Fax:
Signature:	Date:

AASM American Academy of SLEEP MEDICINE

CANADIAN SOCIETY OF RESPIRATORY THERAPISTS
SOCIÉTÉ CANADIENNE DES THÉRAPEUTES RESPIRATOIRES

BCSRT BC Society of Respiratory Therapists