CPAP PRESCRIPTION AUTHORISATION

**To Whom It May Concern**

Your patient wishes to purchase a CPAP Machine from our Hope2Sleep Charity, and in order to supply this we would kindly request you give us approval by filling in the short form below. Please either give this form back to your patient for he/she to return to us, or alternatively you can send the completed form back to us at the address on this form or via email at sales@hope2sleep.co.uk in order for us to issue the machine as soon as possible. You are also welcome to call us if you have any queries on 01482 374181.

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| Patient’s Name:  Patient’s Address:  APAP Pressures, if necessary to alter:-  Minimum Pressure: Maximum Pressure:  If CPAP Mode is necessary, Fixed Pressure:  Ramp Time: Any other settings needed  Hospital or Clinic  Name of Clinician  Position of Clinician  Signature of Clinician  Date of Authorisation  **Many Thanks** |