



The Foundation

HUMBOLDT-DEL NORTE FOUNDATION FOR MEDICAL CARE

A partner in the delivery of medical care in Humboldt and Del Norte counties since 1963.

CPAP/BiPAP Compliance Information REQUIRED FOR ALL CONTINUING USE REQUESTS Please complete and attach to authorization request.

Patient's Name: _____

Date of birth: _____

Name of person/representative gathering information from the patient:
_____ Date of interview: _____

Business Name: _____

Equipment Use: CPAP BiPAP

How many NIGHTS per WEEK are using your CPAP/BiPAP? _____

How many HOURS per NIGHT are using your CPAP/BiPAP? _____

Since using your CPAP/BiPAP, how do you feel?

Much Better Better Same Worse

Are you sleeping through the night?

Yes No Comments: _____

Are you tired throughout the day?

Yes No Comments: _____

Any additional comments: