HUMBOLDT INDEPENDENT PRACTICE ASSOCIATION
2662 HARRIS STREET, EUREKA, CA 95503-4856
PHONE: (707) 443-4563 FAX: (707) 442-2047
www.humboldtipa.com

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: