Rx Request for Transcend CPAP Purchase

ATTENTION PHYSICIAN: This patient has purchased CPAP equipment from Transcend. We do not currently have their prescription on file and require it in order to ship the patient's equipment to them. **Please complete this form with your signature and return it by fax to 651-413-3477 or email at medicalrecords@mytranscend.com**. Thank you.

Patient Information

Name: _____

Address: _____

City, State Zip: _____

Phone: _____

DOB: _____

Diagnosis: G47.33 Obstructive Sleep Apnea

Physician Information

Name: _____

Address: _____

Phone: _____

Fax: _____

CPAP equipment purchased (please indicate prescription settings for selected products):

☒ CPAP Pressure setting:____cmH2O

Ramp time(0-45min): ____min Starting ramp pressure: ____cmH2O

Pressure relief (max= 3): ☐ OFF ☐ 1 ☐ 2 ☐ 3

☐ CPAP Mask

Physician Signature:_____ **Date:**_____

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medicalrecords@mytranscend.com