Apguard Medical Inc. 818-713-0202 Fax 818-713-0879

CPAP/BiPaP Phone Questionnaire

Patient Name_____ Acct #_____ DOB____/_____/_____ Date____/_____/_____

☐CPAP ☐Bi-Level Mfg/Model_____ ☐Htd Humid Mfg_____ Rx_____ CWP

1. Are you using the CPAP/Bi-Level machine regularly each night? ☐ Yes ☐ No (average number of hours/night:_____)
2. Are you sleeping more soundly while using the CPAP/Bi-Level? ☐ Yes ☐ No

Details:_____

_____

3. Are you feeling more rested during your wake time since you have been using the CPAP/Bi-Level? ☐ Yes ☐ No

Details:_____

_____

4. Do you need your supplies replaced? ☐ Yes ☐ No If yes, check all that apply:

			Type & Size
Hybrid Nasal Full Face Mask	K0553	1 per 3 months	_____
Nasal Device (Nasal Interface)	A7034	1 per 3 months	_____
Nasal Device Cushion (Replacement)	A7032	2 per month	_____
*Oral Cushion (Replacement)	K0554	2 per month	_____
*Nasal Seal (Replacement)	K0555	2 per month	_____
Nasal Pillows (Pair)	A7033	2 per month	_____
Full Face Mask (Full Interface)	A7030	1 per 3 months	_____
Full Face Cushion (Replacement)	A7031	1 per month	_____
Headgear (Interface Support)	A7035	1 per 6 months	_____
Chinstrap	A7036	1 per 6 months	_____
Copper Core Tubing F& P	A4604	1 per 3 months	_____
Large Bore Tubing (short or long)	A7037	1 per 3 months	_____
Humidifier Chamber (Replacement)	A7046	1 per 6 months	_____
Filter, Disposable	A7038	2 per month	_____
Filter, Non-Disposable	A7039	1 per 6 months	_____

5. Are you cleaning your supplies on a regular basis? ☐ Yes ☐ No (Review cleaning procedures to assess response.)
6. If there are problems or questions with the use of the device or supplies, please list:
   Confirm phone number(s), home address and physician information. If incorrect, please note changes below...

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Company Representative_____ Forwarded to ☐CSR ☐RT Dept on ____/_____/_____