# Application Form for Authorisation for CPAP Therapy

**Personal details**

Name of insured person:

Date of birth: __ __ - __ __ - __ __ __ __

Address | Town/city

Health insurance company | Policy number:

Date when wound arose: __ __ - __ __ - __ __ __ __ | Date treatment started __ __ - __ __ - __ __ __ __

**Already in possession of an MRA device?**

○ Yes ○ No

**Sender**

Name of institution:

Name of specialist:

| Medical indication for OSAS | Before | After | |
|---|---|---|---|
| Apnoea index | | | (number per hour) |
| Apnoea/hypopnoea index | | | (number per hour) |
| Desaturation index | | | (number per hour) |
| Lowest desaturation | | | % |
| Respiratory Arousal index | | | (number per hour) |

BMI:

Other:

Examination method: ○ PG ○ PSG

| Symptoms<br>0 (absent, + (slight to moderate), ++ (severe) | Before | After |
|---|---|---|
| Concentration disorders | | |
| Hypersomnolence, daytime | | |
| Mood disorders | | |
| Elevated irritability | | |

Equipment for CPAP therapy: ○ CPAP ○ APAP ○ BPAP

Humidifier: ○ Yes ○ No

Pressure setting: cm H20

Slope/Pressure buildup: minutes

Test placement period:

Test placement succesful: ○ Yes ○ No

Notes:

**Signature + Name stamp**

**Date:** __ __ - __ __ - __ __ __ __