

CAMP MILLHOUSE CPAP/BIPAP ORDER SHEET

Name: (First) _____ (Last) _____
Camper uses CPAP _____ BIPAP _____ CPAP/BIPAP BEGAN _____
CPAP/BIPAP is to be used: only overnight: YES _____ NO _____ daytime naps YES _____ NO _____
CPAP/BIPAP necessary due to the following diagnosis: _____ _____

SETTING ON MACHINE

CPAP: IPAP _____ CM H2O	LAST REVIEWED/ADJUSTED _____
BIPAP: IPAP _____ CM H2O	EPAP _____ CM H2O
HEATED HUMIDIFER: YES _____ NO _____	
OXYGEN: YES _____ LPM OR _____ %FIO2	NO _____

CONTACT INFORMATION FOR CPAP/BIPAP PROVIDER

Home Health Agency/Provider of Equipment _____
Phone Number _____ Contact _____
Afterhours Phone Number _____
Physician who ordered/monitors CPAP/BIPAP _____

ADDITIONAL ORDERS/COMMENTS

Specific directions/orders/comments not included previously on form: _____ _____
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**CAMPERS ARE REQUIRED TO PROVIDE ALL CPAP/BIPAP SUPPLIES:
CPAP/BIPAP MACHINE, TUBING, MASK/NASAL PILLOW, GROUNDED EXTENTION CORD, AND
DISTILLED WATER THAT WILL BE NEEDED DURING THE CAMP WEEK.**

► Physician Signature (Original physician signature required)	Date:
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