**AUTO/ CPAP/ MASK PRESCRIPTION**

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| **Hospital:** | | | | |
| **Patient’s Name:** | | | | |
| **Date of Birth:** | | | | |
| **Address:** | | | | |
| **Phone No:** | | | | |
| **Medical Card: Yes / No** | **Card No:** | | | **Expiry Date:** |
| **Diagnosis:** | | | | |
| **Consultant Physician:** | | | | |
| **Mask Type:** | **Nasal:** | | | **Full:** |
| **Pressure Setting:** | | | | |
| **Overnight Oximetry: Yes / No** | | | **Date Required:** | |
| **Ventilator Type / Device Type:** | | | **Humidification: Yes / No** | |
| **cmH2O (min):** | | | **cmH2O (max):** | |
| **Ramp/Settling Time:** | | | | |
| **Prescribers Signature:**  This prescription is issued under National Drawdown Framework Agreement for Respiratory Sleep Therapy – HSE 7768 , the Resmed PEI Device and Managed Care Service Package best meets the clinical, domestic and personal needs of the individual service user. | | | | |
| **Print Name:** | | | | |
| **Date:** | | | | |
| **Comments:** | | | | |
| **Email to: resmedpei@pei.ie**  **ResMed PEI,**  **M50 Business Park,**  **Ballymount Road Upper,**  **Ballymount,**  **Dublin 12**. | | **Tel. No.:  +353 1 419 6900**  **Fax No.: +353 1 4295760** | | |