**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** |