**ASV PRESCRIPTION**

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| **Hospital:**  | **Consultant Physician:**  |
| **Patient’s Name:**  | **D.O.B:**  |
| **Address:**  |
| **Phone No:**  |
| **Medical Card: Yes/ No** | Card No:  | **Expiry Date:**  |
| **Diagnosis:**  |
| **Mask Type Required:**  |
| **Device / Ventilator Type Required: External Battery Required: Y / N** |
| **Replacement Airtouch Cushions Required:**  |
| **Mode:**  |
| **Min EPAP: Max EPAP:**  | **Min PS: Max PS:**  |
| **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 9068861****Fax No.: +353 1 4295760****Wed: www.resmedpei.com** |