**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** | | |