

# CPAP ORDER FORM



	Private patient? Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient's name:	Address:
Date of birth:	
Diagnosis:	
Next of kin:	
Medical card number:	Medical card expiry date:
Telephone number:	Mobile telephone number:

Prescription details	
<b>Please select mask</b> Nasal mask: <input type="checkbox"/> Nasal pillows: <input type="checkbox"/> Full face mask: <input type="checkbox"/> Please specify if a specific mask type and size is required: <input type="text"/> <small>(alternative manufacturers masks will incur an additional charge.)</small>	<b>Auto CPAP pressure setting</b> Default Auto settings: <input type="checkbox"/> (Min 4 Max 20cm H <sub>2</sub> O) <b>or</b> Minimum pressure: <input type="text"/> cm H <sub>2</sub> O (Min 4cm H <sub>2</sub> O) Maximum pressure: <input type="text"/> cm H <sub>2</sub> O (Max 20cm H <sub>2</sub> O)
<b>CPAP pressure setting</b> Pressure setting: <input type="text"/> cm H <sub>2</sub> O (Min 4cm H <sub>2</sub> O) C-Check: <input type="checkbox"/> (please complete pressure setting)	
<b>Optional features</b> Opti-Start (only available in Auto mode) <input type="checkbox"/> A-Trial <input type="checkbox"/> No of days: <input type="text"/> (3 to 30 days, 30 days will be applied by default) Heated humidification required? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Additional details

Prescribers details	
Print name:	Hospital:
Signed:	Ward:
Date:	Bleep number:

Send to
<b>All patients:</b> Please fax a copy of this order to Air Liquide Healthcare. <b>Medical card patients:</b> Please also fax a copy of this to the relevant PCCC.