Air Liquide HEALTHCARE

CPAP ORDER FORM

Patient's name:	Address:	
Date of birth:		
Diagnosis:	Eircode:	
Next of kin:	Email address:	
NOK telephone number:	Private patient? Yes ☐ No ☐	
Patient's telephone number(s):	Medical card number:	Expiry Date:

Prescription details

Please select mask

Nasal mask: ☐

Nasal pillows: ☐

Full face mask: ☐

Please specify if a specific mask type and size is required:

(alternative manufacturers masks will incur an additional charge.)

Auto CPAP pressure setting

Default Auto settings: ☐ (Min 4 Max 20cm H_2O)

or

Minimum pressure: _____ cm H_2O (Min 4cm H_2O)

Maximum pressure: _____ cm H_2O (Max 20cm H_2O)

Fixed CPAP pressure setting

Pressure setting: _____ cm H_2O (Min 4cm H_2O, Max 20cmH20)

Optional features

Heated humidification required? Yes ☐ No ☐

Ramp/Soft Start Yes ☐ No ☐ Ramp start pressure: _____ Ramp Time (5-45mins)_____

C-Check: ☐ (please complete pressure setting)

Opti-Start (only available in Auto mode) ☐ A-Trial ☐ No of days: _____ (3 to 30 days, 30 days will be applied by default)

Additional details

Prescriber details

Print name:	Hospital:
Signed:	Ward & room number:
Position:	Bleep number:
Contact telephone number & email (should we need to contact you to clarify settings):	

Send to

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

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