

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	
<p>Please select mask</p> <p>Nasal mask: <input type="checkbox"/></p> <p>Nasal pillows: <input type="checkbox"/></p> <p>Full face mask: <input type="checkbox"/></p> <p>Please specify if a specific mask type and size is required: <input type="text"/> <small>(alternative manufacturers masks will incur an additional charge.)</small></p>	<p>Auto CPAP pressure</p> <p>setting Default Auto <input type="checkbox"/> (Min 4 Max 20cm H₂O)</p> <p>settings: or</p> <p>Minimum pressure: <input type="text"/></p> <p>Maximum pressure: <input type="text"/></p> <p>Remote Download Modem Yes / No</p> <p>Encore anywhere remote compliance software.</p>
CPAP pressure setting	
Pressure setting: <input type="text"/> cm H ₂ O (Min 4cm H ₂ O) C-Check: <input type="checkbox"/> (please complete pressure setting)	
Optional features	
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 Comments	
Prescribers details	
Print name:	Hospital:
Signed:	Ward:
Date:	Bleep number:
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.	