

# Mechanical Ventilator Equipment Order

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referral Line: 800-834-4234 Referral Fax Line: 847-931-7138

PATIENT INFORMATION							
Patient:						DOB:	
<input type="checkbox"/> M <input type="checkbox"/> F	Height:	Weight:	<b>PLEASE ATTACH COMPLETE DEMOGRAPHIC / INSURANCE INFORMATION</b>				
DIAGNOSIS							
<input type="checkbox"/> Chronic Respiratory Failure (J96.10) consequent to COPD (J44.9)				<input type="checkbox"/> Restrictive Thoracic Disorder: _____			
<input type="checkbox"/> Neuromuscular Disorder: _____				<input type="checkbox"/> Other: _____			
ORDER							
<input type="checkbox"/> <b>Breas Vivo 50/65 E0466 Non-Invasive Mechanical Ventilator</b>							
Modes & Parameters							
<input type="checkbox"/> PSV (TgV)	<input type="checkbox"/> PCV (A+TgV)	<input type="checkbox"/> PCV (SIMV)	<input type="checkbox"/> PCV (A)	<input type="checkbox"/> PCV (MPV)	<input type="checkbox"/> VCV (A)	<input type="checkbox"/> VCV (SIMV)	<input type="checkbox"/> VCV (MPV)
TgV:	TgV:	V <sub>T</sub> :	PEEP:	RATE:	V <sub>T</sub> :	V <sub>T</sub> :	V <sub>T</sub> :
PEEP:	PEEP:	PEEP:	RATE:	INSP. PRES:	PEEP:	PEEP:	RATE:
RATE:	RATE:	RATE:	INSP. PRES:		RATE:	RATE:	
MAX PRES:	MAX PRES:	INSP. PRES:			SUP. PRES:		
MIN PRES:	MIN PRES:						
To specify HOME ADJUST, enter parameters as ranges, i.e. 12-16							
<b>ALARMS</b> <input checked="" type="checkbox"/> RT to set appropriate alarms unless specified below:							
<input type="checkbox"/> V <sub>E</sub> ↑	<input type="checkbox"/> V <sub>E</sub> ↓	<input type="checkbox"/> PEEP ↑	<input type="checkbox"/> PEEP ↓	<input type="checkbox"/> Press. ↑	<input type="checkbox"/> Press. ↓	<input type="checkbox"/> Rate ↑	<input type="checkbox"/> Rate ↓
						Disconnect	
						<input checked="" type="checkbox"/> On <input type="checkbox"/> Off	
						Apnea	
						<input type="checkbox"/> 20 seconds <input type="checkbox"/> Other interval: _____	
<input checked="" type="checkbox"/> RT to titrate any parameters not specified including set Rise Time, Inspiratory Time, Trigger, Flow Pattern and other comfort settings. <input type="checkbox"/> RT to titrate ALL parameters to RANGES SPECIFIED ABOVE <input type="checkbox"/> ETCO <sub>2</sub> Monitoring: <input type="checkbox"/> Continuous x30 days <input type="checkbox"/> Quarterly <input type="checkbox"/> Other interval: _____ <input type="checkbox"/> Titrate all ventilator parameters to keep ETCO <sub>2</sub> greater than _____ and less than _____ <input type="checkbox"/> Oxygen bled into vent at _____ LPM <input type="checkbox"/> Titrate oxygen to keep O <sub>2</sub> saturation ≥ _____ SpO <sub>2</sub> Hours of use: <input type="checkbox"/> 8-24 hrs/day <input type="checkbox"/> Continuous <input type="checkbox"/> Other: _____ Length of need: <input type="checkbox"/> 99 <input type="checkbox"/> Other: _____ Interface: <input type="checkbox"/> Mask: _____ Other: _____ Supplies: <input checked="" type="checkbox"/> Circuit <input checked="" type="checkbox"/> Bacterial Filters <input checked="" type="checkbox"/> Dust filters <input checked="" type="checkbox"/> Quarterly Download & Clinical Assessment including oximetry, breath sounds, oxygen titration, and alarm adjustment to be performed							
<input checked="" type="checkbox"/> Patient/Caregiver to understand disease condition, outcomes, & need for mechanical ventilator operation, troubleshooting, supplies and infection control. <input checked="" type="checkbox"/> Patient/Caregiver to understand & be able to handle unexpected situations and the importance of reducing future admissions for exacerbation of disease process.							
Comments:							
PHYSICIAN INFORMATION							
Ordered by:						Date:	
Practitioner's Name:			NPI:		Phone:		Fax:
Practitioner's Signature:			Date:		Special Instructions:		