Total Home Health
An AeroCare Company

Mechanical Ventilator Equipment Order

Phone:_____ Fax: _____

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

PATIENT INFORMATION

Patient:			DOB:
☐ M ☐ F	Height:	Weight:	PLEASE ATTACH COMPLETE DEMOGRAPHIC / INSURANCE INFORMATION

DIAGNOSIS

☐ Chronic Respiratory Failure (J96.10) consequent to COPD (J44.9) ☐ Restrictive Thoracic Disorder: _____

☐ Neuromuscular Disorder: _____ ☐ Other: _____

ORDER

☐ **E0466 Non-Invasive Mechanical Ventilator**

☐ **E0465 Invasive Mechanical Ventilator**

Vent Manufacturer / Model:	
Mode:	
Parameters:	
Alarms:	

☑ RT to titrate any parameters not specified including set Rise Time, Inspiratory Time, Trigger, Flow Pattern and other comfort settings.

☐ RT to titrate ALL parameters to RANGES SPECIFIED ABOVE

☐ Oxygen bled into vent at _____ LPM

☐ Titrate oxygen to keep O2 saturation ≥ _____ SpO2

Hours of use: ☐ 8-24 hrs/day ☐ Continuous ☐ Other:_____

Length of need: ☐ 99 ☐ Other: _____

Interface: ☐ Mask: _____ Other: _____

Supplies: ☑ Circuit ☑ Bacterial Filters ☑ Dust filters

☑ Quarterly Download & Clinical Assessment including oximetry, breath sounds, oxygen titration, and alarm adjustment to be performed

☑ Patient/Caregiver to understand disease condition, outcomes, & need for mechanical ventilator operation, troubleshooting, supplies and infection control.

☑ 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:	