Total Home Health
An AeroCare Company

Mechanical Ventilator Equipment Order

Phone: (847) 931-9300 Fax: (847) 931-7138

PATIENT INFORMATION - Please attach complete demographic / relevent notes / insurance information

Patient Name: ____________________ Sex: ❑ Male ❑ Female

DOB: ____________________ Patient Height: __________ Patient Weight: __________

DIAGNOSIS

❑ (Z99.11) Ventilator Dependence

❑ (J96.10) Chronic Respiratory Failure

❑ Neuromuscular Disorder: ____________________

❑ (J96.10) Chronic Respiratory Failure (J44.9) consequent to COPD

❑ (P27.9) Unspecified Chronic Respiratory Disease

❑ (P27.1) Severe Brochopulmonary Dysplasia

❑ Restrictive Thoracic Disorder: ____________________

❑ Other: ____________________

ORDER | ❑ E0465 TRILOGY 100 INVASIVE VENTILATOR

Pressure Control Modes				Volume Modes	
Mode: **S** (Sponteous)	**ST** (Spont/Time)	**PC** (Press Control)	**PC-SIMV**	**AC**	**SIMV**
AVAPS ❑ ON ❑ OFF	**AVAPS ❑ ON ❑ OFF**	**AVAPS ❑ ON ❑ OFF**	InspPress: ______	Vt: ______	Vt: ______
IPAP: ______	IPAP: ______	IPAP: ______	PS: ______	PEEP: ______	PS: ______
EPAP: ______	EPAP: ______	EPAP: ______	PEEP: ______	RR: ______	PEEP: ______
AVAPS ON:	Insp Time: ______	Insp Time: ______	RR: ______	Ti: ______	RR: ______
VT: ______	RR: ______	RR: ______	Ti: ______		Ti: ______
IPAPmax: ______	AVAPS ON:	AVAPS ON:			
IPAPmin: ______	Vt: ______	Vt: ______			
APNEA Set ____secs	IPAPmax: ______	IPAPmax: ______			
APNEA Rate: ______	IPAPmin: ______	IPAPmin: ______			

ALARMS: ❑ RT to set appropriate alarms unless specified ❑ **IF USING AVAPS: RATE SET AT 5**

❑ RT to titrate parameters such as Rise Time, Trigger, Flow Pattern, and other comfort settings

❑ RT to titrate ALL parameters to any RANGES SPECIFIED ABOVE

❑ Oxygen bled into ventilator at __________ LPM

❑ Titrate oxygen to keep patient's oxygen saturation above __________ % Sp02

Hours of use per day ventilator is to be used: ______ Continuous / ______ Other

Length of Need: __________ 99 Months / __________ Other

Supplies: ❑ HME ❑ Heated Humidity ❑ Circuit ❑ Bacteria Filter ❑ Inlet Filter

Type/Size of Trach Tube: ____________________

❑ **CLINICAL ASSESSMENT:** Monthly Download, Oximetry, Breath Sounds, and Oxygen Titration

❑ 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**