Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT

2100 Landmeier Rd | Elk Grove Village, IL 60007
PHONE: 800-834-4234 | FAX: 847-931-7138

Written Order Prior to Delivery
Ventilator and Supplies

ASTRAL NON-INVASIVE VENTILATOR

Patient Name	Insurance ID/Group
Address	Insurance Name Insurance Phone
Phone	Order Date
DOB	Height/Weight
Estimated Length of Need (i.e. 99=lifetime)	ICD-10

HCPCS Code: E0466 – Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

Astral: ☐ Astral 100 ☐ Astral 150

Astral Mode:

☐ CPAP ☐ PAC ☐ IVAPS ☐ PS ☐ P-SIMV ☐ V-SIMV
☐ ACV ☐ PS/SVI ☐ PACV/SVI

Astral Settings:

IPAP/Pcontrol		Rise Time	msec
EPAP/PEEP		Ti Min	sec
PS/PS Min		Ti Max	sec
Pcontrol/PS Max		Trigger	
Target Pt rate/Resp rate		Cycle	%
Ti	sec	Vt	mL
Target Va	L/m	Ave Vt/kg	6-8 mL

Supplemental Oxygen:	FiO2 / lpm: ______	
Humidification:	☐ Heated Humidifier	☐ Other _____

Download ventilation reports with software? ☐ Yes, download frequency _____ ☐ No

Patient Interface: ☐ mask ☐ MPV ☐ other: _____

Hours of use ☐ continuous ☐ during sleep ☐ other: _____

Clinical assessment to be performed to determine device alarm settings

Additional orders:

Please attach the following:

- Progress notes/face to face evaluation indicating patient need for prescribed equipment/supplies
- Test results
- Patient demographics sheet

In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature below certifies the medical need for these items for this patient. This form must be SIGNED and DATED by the prescribing Physician prior to dispensing supplies and medical equipment.

Physician Name:		Physician NPI:	
Physician Address:		Physician Phone:	
Physician Signature:	No stamps please – not valid by law	Date:	

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