Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT

2521 Technology Drive, Suite 214 | Elgin, IL 60124
PHONE: 800-834-4234 | FAX: 847-931-7138

Written Order Prior to Delivery
Ventilator and Supplies

TRILOGY 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: E0465 – Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)

Circuit Type: ☐ Passive ☐ Active

Trilogy Settings:

☐ SIMV ☐ AC ☐ CV ☐ PC-SIMV ☐ PC ☐ AVAPS

Vt: _____	Breath Rate: _____	Inspiratory Time: _____	sigh ☐ on ☐ off	☐ Mouthpiece Ventilation (MPV)
Pressure: _____	PS: _____	EPAP/PEEP: _____	IPAP: _____	

☐ AVAPS IPAP min: _____ IPAP max: _____ Vt target: _____
AVAPS rate: _____ Max Pressure: _____

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

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

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

Second ventilator needed for portability (wheelchair mounted)? ☐ Yes ☐ No

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:	