BellevueHealthcare

NON-INVASIVE VENTILATOR ORDER FORM

- Fax completed form to 1.425.467.6661 -

Last Name: ____________________________ **First Name:** __________________________ **MI**: ___ **DOB**:________________

Height: _______ **Weight:** _______ **Alternate Contact**: ____

Delivery Address / Location (room #): ____

City: ________________ **State**: __ **Zip Code**: _______ **Phone Number**: (___) ___________ **D/C Date/Time**: _______________

* Please attach patient demographics and insurance information with order.

ORDERED BY

Physician:____ **NPI**: ______________________________________

Physician Signature: ____ **Date**: _____________________________________

Diagnosis** (ICD-10 Codes):____

Length of Need (99=lifetime):_______ **Hours of Use**: ☐ Nocturnal ☐ Continuous ☐ Other: ____________________

*** Please include progress notes detailing the life threatening nature of this disease AND the reason(s) why a BiPAP has been considered and/or tried and ruled out.

EQUIPMENT ORDERED

☐ **Respironics Trilogy 100 Ventilator** (HCPCS: E0464, E0466)

☐ **Heated Humidifier** (HCPCS: E0562)

☐ ____

SETTINGS

Primary Mode

☐ AVAPS-AE with Target Tidal Volume

Settings

Max pressure: _____ Ps Min: ___ Ps Max: ___

EPAP Min: ____ EPAP Max: ____ Rate: _____

Vt: ______ Insp time: _______ (if rate = “auto”, then “N/A”)

Secondary Mode

☐ Assist Control with mouthpiece ventilation

☐ Pressure Control with mouthpiece ventilation

Settings

Vt: _____ Insp time: ______ (if rate = “auto”, then “N/A”)

Other: ____

☐ **Titrate to comfort** ☐ **Oxygen bled in at ______ lpm**