Invasive Ventilator Standard Written Order

Fax: 602-428-6841
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Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to coverage criteria sheet for all required documentation.

VENTILATOR:

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in. Weight: _____ lbs.

Scheduled Date of discharge from hospital: _____ Note: We ask for at least one week to coordinate patient discharges.

Settings:

AVAPS Select a mode: ☐ PC ☐ S/T ☐ S ☐ TVT

_____ ml (6-8 mg/kg of IBW, NOT actual weight. IBW is based on height)

AVPAS Rate: _____ 5 (5 is standard)

Respiratory Rate: _____ (10 or 2 below resting respiratory rate)

IPAP Max: _____ (4-44, standard around 25)

IPAP Min: _____ (standard between 5 and 10, +4 of EPAP)

EPAP: _____ (4-10, at least 4 below IPAP min)

SIMV: VT: _____ Rate: _____ PS: _____ PEEP: _____ I Time: _____

AC: VT: _____ Rate: _____ PEEP: _____ I Time: _____

PC-SIMV: VT: _____ Rate: _____ PEEP: _____ I Time: _____ PS: _____ (above PEEP)

PC: IPAP: _____ EPAP: _____ Rate: _____ I Time: _____ Pressure: _____ PEEP: _____

S/T or T: IPAP: _____ EPAP: _____ Rate: _____ I Time: _____ Rise Time (1-6): _____ Ramp (5-45 min): _____

S: IPAP: _____ EPAP: (at least 4) _____ Rise Time: _____ Ramp: _____

CPAP: _____ Ramp: _____

Supplemental Oxygen (if applicable): FI02 or LMP _____ Titrate O2 to maintain SaO2> _____

Humidification: ☐ Heated Humidifier ☐ HME

Trach Type and Size: _____ Hours of Use: ☐ Continuous ☐ Other: _____

Supplies:

- ☐ Adapter, Heated Wire (A9999) 2/PRN
- ☐ Ambu Bag (S8999) 1/PRN ☐ Pediatric w/peep valve ☐ Adult
- ☐ Circuit, Disposable Ventilator (A9900) 5/month
- ☐ Exhalation Port (A9900) 5/month
- ☐ Flex Adapter 5/month
- ☐ Bacteria Filter (A9999) 5/month
- ☐ PRN Filters: Air/Intake Filter 1/6 mo Fan Filter 1/6 mo Particulate Filter 1/mo White Pollen Filter 1/mo
- ☐ HME when mobile (A4483) 31/month
- ☐ Inline Suction Catheter (A4605) Size _____ Qty____/mo
- ☐ IV Pole and Bracket (E0776) 1/PRN
- ☐ Sterile Water (A4217) 31,000mL max/month
- ☐ Temperature Probe (A9900) 2/month
- ☐ Ventilator Check 1/month
- ☐ Water Chamber (A9900) 5/month
- ☐ Heated Inspiratory Line (A4618) 5/month

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____