DASCO HOME MEDICAL EQUIPMENT

NON INVASIVE VENTILATION ORDER FORM

Our family serving yours since 1987

Patient Name: ________________________________ **Phone/Cell #**___________**DOB:**__________

Address: ____**Ht**________**Wt**________

Date prescribed: _____ / _____ / _________ **LON if less than a lifetime :** ___________ (1-99, 99= lifetime)

□ *Copy of demographic information?* □ *Yes* □ *No* □ *Copy of insurance information?* □ *Yes* □ *No*

Diagnosis

Chronic Respiratory Failure w/ COPD	Thoracic Restrictive Diseases	Neuromuscular Disease
□ Chronic Respiratory Failure w/ COPD	□ Scoliosis □ Kyphosis □ Sarcoidosis □ Interstitial Lung Disease □ Pulmonary Fibrosis □ Obesity Hypoventilation Syndrome □ Pneumonectomy/Lobectomy □ Other: ____________________	□ ALS □ Myasthenia Gravis □ Muscular Dystrophy □ Multiple Sclerosis □ Spinal Muscle Atrophy □ Other: ____________________

□ IVAPS (Resmed with remote monitoring)

□ **Standard Setting**

Mode: IVAPS
PS Min: 6cmH2O EPAP: 5cmH2O
PS Max: 20cmH2O Target Rate:15
Vt: Patient Height (to be calculated for TV) ________
Vt: 6-8ml/Kg of ideal body weight
Approve DASCO clinician to calculate Vt as needed □

□ **Custom Setting**

Mode: __________ PAP MAx: __________
EPAP/PEEP: __________ RR: __________
PS Min: __________ PS Max: __________
Vt: __________

□ AVAPS (Respironics without remote monitoring)

□ **Standard Setting**

Mode: AVAPS AE AVAPS Rate 5 cmH2O
PS Min: 6 cmH2O Max Pressure: 30 cmH2O
PS Max: 26 cmH2O BUR:_____ breaths/min □ Auto
EPAP Min: 4cmH2O EPAP Max: 14cmH2O
Vt: 6-8ml/Kg of ideal body weight
Approve DASCO clinician to calculate Vt as needed □

□ **Custom Setting**

Mode: _________ AVAPS Rate _________
PS Min: _________ Max Pressure: _________
PS Max: _________ BUR:_____ breaths/min □ Auto
EPAP Min: _________ EPAP Max: _________
Vt:_________

Other equipment and supplies

□ Oxygen Bleed in @ ___ lpm or ___ lpm _____ hpd □ Portable System □ Nasal Mask(1/3mo) □ Full Face Mask(1/3mo)
□ Heated Humidifier □ Exhalation Port □ Vent Circuits □ Heat Moisture Exchange
□Overnight Pulse Ox with NIV on □ RA □ O2 ___lpm

Documentation in Medical Records

□ Patient requires volume ventilation and all other alternative therapies, including Bilevel, have been considered and ruled out due to the severity of the disease state, weak breathing muscles and potential life threatening condition including CO2 retention probability of acute exacerbation, patient requires ventilation to be used during the day as needed, in addition to every night usage with face mask.

By signing below, this validates the prescription above & indicates the patient has been informed that DASCO will contact them regarding of this referral.

X____ _____/_____/_____ ____________________

Physician's Handwritten Signature ***Date*** ***NPI***

____

Physician's Printed Name ***Address*** ***Phone***

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