INVASIVE VENTILATOR STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone: _____ **Ins ID #:** _____

Patient DOB: _____ **Sex:** **(M/F)**

Note: Ventilators are commonly covered for the following diagnosis groups: neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

VENTILATOR:

Date of Last Provider Visit: _____

Diagnosis and Code: _____

Scheduled Date of discharge from the hospital: _____

Length of Need (# of months):_____1-99 (99=lifetime)

Note: We ask for at least one week to coordinate patient discharges

Patient Height: _____ Patient Weight: _____

Settings:

AVAPS Select a mode: ☐ PC ☐ S/T ☐ S ☐ TVT_____ml (6-8mg/kg of IBW, NOT actual weight. IBW is based on height)

AVAPS 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, atleast 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 (5-45min): ____

S: IPAP: ____ EPAP (atleast 4): ____ Rise Time: ____ Ramp: ____

CPAP: ____ Ramp: _____

Supplemental Oxygen (if applicable): FI02 or LPM _____ Titrate 02 to maintaian Sa02> _____

Humidification: ☐ Heated Humidifier ☐ HME

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

Supplies:

☐ Standard:

Disposable Water Chamber 4/mo with Sterile water 31,000mL month max
Bacteria Filters 4/month
Reusable Ventilator Circuit 1 every 3 months
Full Face Mask 1 every 3 months with Full Face Cushion 1/month

☐ HME (A4483) 31/month
☐ Inline Suction Catheter (A4605) Size ____ Qty ____/mo
☐ Exhalation Port (A9900) 5/month
☐ Flex Adapter (A4649) 5/month
☐ Mouthpiece Ventilation Circuit 4/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: _____

Provider's Name: _____ Telephone: _____