APRIA®

Invasive Ventilation Rx Order

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____ Start of care date _____

PATIENT INFORMATION

Patient name (Last, First) _____ DOB _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Patient height _____ Patient weight _____

Patient address: Street _____ City _____ State _____ Zip _____

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes.

Diagnosis _____ ICD-10 code _____ Diagnosis _____ ICD-10 code _____

Device: ☐ Initial ☐ Revision or Setting Change ☐ Device Replacement – *Existing device settings are retained with new settings until trial is completed.*

Equipment Ordered: Home Ventilator with supplies used ☐ with invasive interface (E0465) ☐ with cough (E0468)

Estimated length of need: _____ months (99 = lifetime) **Supplies:** ☐ Initial ☐ Reorder

PRESCRIBED SETTINGS FOR INVASIVE VENTILATION

☐ Licensed Professional (LP) is authorized to titrate ventilator parameters only within prescribed mode of ventilation and ranges to maximize patient's ventilatory support, adherence to therapy, and comfort.

React MODES: ☐ AC- Volume (VC and CV) ☐ SIMV- Volume ☐ Volume Targeted - SIMV (SIMV + PRVC)
☐ AC- Pressure - (PC) ☐ SIMV - Pressure ☐ Volume Targeted- PC (PRVC) ☐ Volume Targeted - PS (AVAPS/PVRS)

Settings: MAX PS/PC: _____ cmH_2O MIN PS/PC: _____ cmH_2O Apnea Rate: _____

PEEP: _____ Vt Volume: _____ ml ☐ Check to allow adjustment within ±100 cc volume

Breath Rate: _____ Inspiratory Time: _____ Press Control: _____ Pressure Support: _____

V+Cough: ☐ + Cough Settings: Exsufflation Press: _____ E-Time _____ Insufflation Press: _____ I-Time: _____ Pause Time: _____

Number of Cough Cycles: _____ Frequency: ☐ BID ☐ PRN ☐ Other ☐ Titrate to achieve effective cough

Astral MODES: ☐ (A)CV ☐ V-SIMV ☐ P(A)CV ☐ P-SIMV ☐ PS ☐ iVAPS

Settings: Tidal volume/Safety/Target volume: _____ PEEP/EPAP: _____ RR: _____ Ti: _____ PControl: _____ PSMax/PS Min: _____

PControl: _____ Max PS/Max Trigger: ☐ Very high ☐ High ☐ Medium (Default) ☐ Low ☐ Very Low ☐ Other _____

Other Device: _____ Mode: _____ Vt Volume: _____ Rate: _____

MAX PS/PC: _____ MIN PS/PC: _____ PEEP/EPAP: _____ Ti: _____ Other: _____

Secondary Ventilator Settings: ☐ Same as above ☐ Other: _____

Is a secondary ventilator required for back-up portability? ☐ Yes ☐ No

Is patient wheelchair dependent and requires a second vent for daytime mobility with one at bedside for nocturnal use? ☐ Yes ☐ No

Alarms: ☐ RT to set appropriate alarms unless specified. ☐ RT to titrate ALL parameters to RANGES SPECIFIED.
☐ RT to titrate any parameters not specified, including set Rise Time, Inspiratory Time, Trigger, Flow Pattern and other comfort settings.

NOTE: The following alarms must never be disabled: 1) Patient disconnect alarms, such as low pressure and/or low exhaled volume, 2) High pressure alarm.

ADDITIONAL ORDERS AND SUPPLIES

Code Status: Resuscitate? ☐ Yes ☐ No **Advance Directive?** ☐ Yes ☐ No

Hours of use: ☐ 24 hrs/day ☐ During sleep ☐ Other (explain): _____

If ventilator is not used 24 hrs/day, document what the patient is using while off the ventilator.

☐ For patients currently on O_2, titrate O_2 to maintain oxygen saturation to 90% or to _____%

☐ Overnight oximetry to be performed on day of setup, using prescribed oxygen

Supplemental oxygen: ☐ Room air ☐ FiO_2 _____% **OR** ☐ _____ LPM

Circuit type: ☐ Single with leak ☐ Single with valve ☐ Other _____

Application: ☐ Use via Trach Trach Brand/Model: _____

Trach Size: _____ ☐ Cuff ☐ Cuffless ☐ Fenestrated ☐ Custom: _____

☐ **Heated Humidifier (E0562)**
☐ **Nebulizer (E0570)** ☐ **HME (E0562)**
☐ **Continuous Oximeter (E0445)**
☐ **Other:** _____

Stationary/Portable Suction (E0600) — Needed to clear secretions: ☐ Stationary Unit ☐ Portable Unit

Dispense the following items: ☐ Suction Canisters 2/mo. ☐ Suction Tubing 2/mo. ☐ Oral Suction Catheter 2/mo.

☐ Tracheal Suction Catheter – Size: _____ FR Qty: _____ /mo. (up to 90 covered by Medicare) ☐ Closed Suction Catheter, 12/mo. – Size: _____ FR

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____

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