Fitzsimmons

Home Medical Equipment

A Division of Fitzsimmons Surgical Supply, Inc.

NON-INVASIVE PRESSURE SUPPORT VENTILATOR

PLEASE FAX COMPLETED FORM TO: (888) 512-1151

FOR SUPPORT PLEASE CALL: (800) 972-8530

PATIENT INFORMATION

PATIENT NAME:	PATIENT DOB:	ORDER DATE:

☑ **NON-INVASIVE PRESSURE SUPPORT VENTILATOR** → W/ □ **RESPIRATORY ASSESSMENT W/OXIMETRY**

W/ □ **O^2 VIA NIPPV/TITRATE TO KEEP SATURATIONS > 90%**

DEVICE & SETTINGS

TRILOGY™ NON-INVASIVE VENTILATOR

□ PC W/AVAPS
TIDAL VOLUME _____ (6-8CC/KG IBW)
IPAP MIN _____ (4CM ABOVE EPAP)
IPAP MAX _____ (30CM)
EPAP/PEEP _____ (5CM)
INSPIRATORY TIME _____ (0.8-1.5SEC)
BACKUP RATE _____ (2-3 BELOW RESTING)

OR

□ AVAPS-AE
TIDAL VOLUME _____ (6-8CC/KG IBW)
MAX PRESSURE _____ (MAX OF 50CM)
PS MIN _____ (4CM ABOVE EPAP MIN)
PS MAX _____ (25CM)
EPAP MIN _____ (5CM)
EPAP MAX _____ (15CM)
BACKUP RATE □ AUTO OR _____ (2-3 BELOW RESTING)
→ IF AUTO, NO INSPIRATORY TIME REQUIRED
INSPIRATORY TIME _____ (0.8-1.5SEC)

□ DUAL SETTINGS → DAYTIME MOUTHPIECE VENTILATION/IPPV FOR RECOVERY BREATHS VIA PORTABLE DEVICE
PC MODE: IPAP _____ (4-40CM) INSPIRATORY TIME _____ (1-1.5SEC)

ASTRAL™ NON-INVASIVE VENTILATOR

☑ SET SYNCHRONY SETTINGS TO PATIENT COMFORT

□ IVAPS
PATIENT HEIGHT _____ (IN)
EPAP MIN _____ (5CM)
EPAP MAX _____ (15CM)
PS MIN _____ (7-9CM)
PS MAX _____ (20-25CM UP TO 40CM)
BREATH RATE _____ (SPONTANEOUS, ≥ 15)
TARGET TIDAL VOLUME _____ (6-8 CC/KG IBW)

OR

□ PS SVT
EPAP/PEEP _____ (5-10CM,10+W/HIGH BMI)
PS MIN _____ (7-9CM)
PS MAX _____ (20-25CM UP TO 40CM)
BACKUP RATE _____ (2-3 BELOW RESTING)
TIDAL VOLUME _____ (6-8CC/KG IBW)

□ DUAL SETTINGS → DAYTIME MOUTHPIECE VENTILATION/IPPV FOR RECOVERY BREATHS VIA PORTABLE DEVICE
PS MODE: PRESSURE SUPPORT _____ (10-20CM) TI MIN _____ (.5-1SEC) TI MAX _____ (1-1.5SEC)
TRIGGER _____ (TOUCH)

HOURS OF USE: DURING SLEEP & PRN (UNLESS NOTED _____) **LENGTH OF NEED:** LIFETIME-99 MOS (UNLESS NOTED _____)

MASK INTERFACE: FIT TO COMFORT (UNLESS NOTED_____) **HUMIDITY:** SET TO COMFORT (UNLESS NOTED_____)

By signing & dating, I attest that I am prescribing a Non-Invasive Pressure Support Ventilator as medically necessary & all other applicable treatments have been tried or considered and ruled out. I have read & understand all safety information & other instructions for use included with therapy clinical guidelines.

PHYSICIAN NAME:	NPI:
PHYSICIAN SIGNATURE:	SIGNATURE DATE: