Confirmation of verbal order for non-invasive mechanical ventilator

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE AND NPI NUMBER
PHONE _____ DOB _____	PHONE _____ NPI# _____

DIAGNOSIS:_____ _____ _____

ORDER DATE: _____ **EST. LENGTH OF NEED (# OF MONTHS):** _____ **1-99** ***(99=LIFETIME)***

HCPCS CODE: E0466 Home ventilator, any type, used with a non-invasive interface (e.g. mask, chest shell)

Astral™ settings

Mode of Ventilation ☐ **PS with Safety Tidal Volume** ☐ Leak Circuit ☐ Valve Circuit

Safety Vt_____ Respiratory Rate_____ Pressure Support (PS)_____

PS Max_____ PEEP_____

Mode of Ventilation ☐ **iVAPS with AE (R6 software or above) (requires Max EPAP)**

Min EPAP _____ Max EPAP _____ Target Pt rate_____ Avg. Vt _____ MinPS_____ MaxPS_____

☐ **Mouthpiece Ventilation** ☐ PS (leak circuit) (R6 software or above) _____

☐ ACV (valve circuit) Vt _____ Ti _____

☐ PACV (leak circuit) P control_____ ☐ Ti_____ ***-or-*** ☐ clinician to adjust Ti for patient comfort

☐ **Supplemental oxygen** LPM _____

Download ventilation reports ☐ Yes download frequency (as needed per practitioner's request)_____

Hours of use ☐ continuous ☐ during sleep

✓Clinical assessment to be performed to determine device alarm settings

Physician's Notes: Documentation required for non-invasive ventilator, with assessment and expected benefit from equipment within 6 mos of order date

PRACTITIONER NAME, ADDRESS, TELEPHONE AND NPI NUMBER

PHONE_____ NPI#_____

PRACTITIONER'S SIGNATURE_____

DATE_____

Reset Form