# Hayat Home Medical

## PRESSURE/VOLUME VENTILATOR

PLEASE FAX COMPLETED FORM TO:
FOR SUPPORT PLEASE CALL: **Phone 708.422.2300**

## PATIENT INFORMATION

| PATIENT NAME: | PATIENT DOB: | ORIGINAL ORDER DATE: | RENEWAL DATE: |
|---|---|---|---|
| | | | |

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

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

## DEVICE & SETTINGS

# BREAS VIVO 45LS VENTILATOR

□ **PSV (TGV) – PRESSURE SUPPORT VENTILATION WITH TARGET VOLUME**

TIDAL VOLUME _____ (6-8CC/KG IBW)
TARGET VOLUME MAX PRESSURE _____ (PRESSURE SUPPORT + PEEP)(RANGE 4 – 50 CMH2O)
TARGET VOLUME MIN PRESSURE _____ (PRESSURE SUPPORT + PEEP)(RANGE 4 - 50 CMH2O)
MIN INSP TIME____ (RANGE – OFF, 0.3 – 3.0 SEC)(SPONTANEOUS BREATHS ONLY)
MAX INSP TIME____(RANGE – OFF, 0.3 – 5.0 SEC)(SPONTANEOUS BREATHS ONLY)
BACK UP INSPIRATORY TIME_____(0.3 – 5.0 SEC)(MECH BREATHS ONLY)
BACKUP BREATH RATE _____ (RANGE 4 – 40)
PEEP _____ (RANGE 2 -20 CMH2O)

**SYNCHRONY SETTINGS**
RISETIME____ (SETTING RANGE 1 – 9 )(1 FAST FLOW, 9 SLOW FLOW)
INSP TRIGGER____ (SETTING RANGE 1 – 9 )(1 MOST SENSITIVE, 9 LEAST SENSITIVE)
EXP TRIGGER____ (SETTING RANGE 1 – 9)( 1 LONG EXHALATION PHASE, 9 SHORT EXHALATION PHASE)

□ TITRATE RISETIME, INSP. TRIGGER AND EXP. TRIGGER FOR PATIENT COMFORT
□ +/- 100 ML VOLUME ADJUSTMENT IF NEEDED
□ DUAL SETTINGS - PLEASE LIST SETTINGS AND MODE OF DELIVERY BELOW ↓

DAYTIME MOUTHPIECE VENTILATION/IPPV FOR RECOVERY BREATHS VIA PORTABLE DEVICE
MPV MODE: **PRESSURE or VOLUME**
PS _____ (RANGE 4 – 50CMH2O) VOLUME _____ml Ti _____ (range 0.3 – 5.0 secS) TRIGGER _____ (1-9) (SETTING RANGE 1 – 9 )(1 MOST SENSITIVE, 9 LEAST SENSITIVE)

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## PRESSURE/VOLUME VENTILATOR

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**PCV (TGV) – PRESSURE CONTROL VENTILATION WITH TARGET VOLUME**

TIDAL VOLUME _____ (6-8CC/KG IBW)
TARGET VOLUME MAX PRESSURE _____ (PRESSURE SUPPORT + PEEP)(RANGE 4 – 50 CMH2O)
TARGET VOLUME MIN PRESSURE _____ (PRESSURE SUPPORT + PEEP)(RANGE 4 - 50 CMH2O)
INSPIRATORY TIME_____(0.3 – 5.0 SEC)
BREATH RATE _____ (RANGE 4 – 40)
PEEP _____ (RANGE 2 -20 CMH2O)

**SYNCHRONY SETTINGS**
RISETIME____ (SETTING RANGE 1 – 9 )(1 FAST FLOW, 9 SLOW FLOW)
INSP TRIGGER____ (SETTING RANGE 1 – 9 )(1 MOST SENSITIVE, 9 LEAST SENSITIVE)

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**VCV – VOLUME CONTROL VENTILATION**

TIDAL VOLUME _____ (6-8CC/KG IBW)
INSPIRATORY TIME_____(0.3 – 5.0 SEC)
BREATH RATE _____ (RANGE 4 – 40)
PEEP _____ (RANGE 2 -20 CMH2O)

**SYNCHRONY SETTINGS**
RISETIME____ (SETTING RANGE 1 – 9 )(1 FAST FLOW, 9 SLOW FLOW)
INSP TRIGGER____ (SETTING RANGE 1 – 9 )(1 MOST SENSITIVE, 9 LEAST SENSITIVE)
FLOW PATTERN____ (SQUARE, DECELERATING)

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**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_____)

# Written Order Astral Non-Invasive Ventilator E0466

Hayat Home Medical Equipment

Territory Manager:_____

Phone: _____-_____-_____ Fax: _____-_____-_____

Email:_____

3518 W. 95th St. • Evergreen Park • IL, 60805
Phone: (708) 422-2300 • Fax: (708) 422-5966

**Patient Information:**

Patient Name: _____ Date of Birth:_____/_____/_____

Patient Phone: _____ Order Date: _____/_____/_____

Order Type: *Choose One:* ☐Initial ☐Revision ☐Replacement Length of Need:_____Months (99=Lifetime)

**Diagnosis:**

☐ Neuromuscular Disease ICD 10:_____

☐ Chronic Respiratory Failure/COPD ICD 10:_____

☐ Restrictive Thoracic Disorder ICD 10:_____

**Ventilator Supplies:**

**Heated Humidification (select)**

☐ Heated Humidifier Qty: 1

☐ Humidifier Chamber Qty: 2/mo.

**Supply Refills (select one)**

☐ 12 months

☐ Other: _____

☐ Ventilator Circuit Qty. 2/mo.

☐ Bacterial Filters Qty. 2/mo.

☐ Mask Replacement Supplies:

Full Face Mask Cushion: 1/mo.
Nasal Mask/Pillow Cushion: 2/mo.
Mask: 1 every 3 mos.
Headgear: 1 every 6 mos.

**Mask (select one)**

☐ Full Face Mask

☐ Nasal Mask

☐ Nasal Pillows

☐ RT to Fit Patient For Mask

**Vent Settings:**

**Hours of Use (select)** ☐ Continuous ☐ HS/Napping/Periods of Dyspnea ☐ Mouthpiece Ventilation Only

☐ **IVAPS-AE**
Pt Height: _____cm
Target Pt Rate: _____bpm
Target Va: _____L/min
Avg Vt: _____ml
Max EPAP: _____cmH20
Min EPAP: _____cmH20
Min PS: _____cmH20
Max PS: _____cmH20
OR
☐ **IVAPS-AE**; RT to titrate settings to maintain Vt of 6-8 ml/kg ideal body weight

☐ **P(A)C**
IPAP: _____cmH20
EPAP: _____cmH20
RR: _____bpm
Safety Vt: _____ml
Pt Height: _____cm

☐ **PS w/ Safety Vt**
PS: _____cmH20
PEEP: _____cmH20
RR: _____bpm
Safety Vt: _____ml

☐ **SIMV**
Tidal Volume: _____ml
RR: _____bpm
PEEP: _____cnH20
PS: _____cmH20

☐ **AC**
Respiratory Rate: _____bpm
Tidal Volume: _____ml
PEEP: _____cmH20

☐ **MPV (select one)**

☐ (A)CV Tidal Volume: _____ml
RR: _____bpm
PEEP: _____cmH20

☐ P(A)CV PC: _____cmH20
PEEP: _____cnH20
RR: _____bpm
Safety Vt: _____ml

☐ RT to titrate settings to patient comfort

**Supplemental Oxygen:**

☐ Supplemental Oxygen at _____LPM via ventilator

☐ Portable Oxygen System Frequency & Duration:
- ☐ 8-10 hours/night (nocturnal)
- ☐ 24 hours/day (continuous)

**Other Orders:**

☐ Titrate 02 to maintain Sa02 > _____%

☐ Transcutaneous C02 Monitoring

☐ Add Patient to AirView Monitoring System

☐ Nocturnal Pulse Oximetry

Name _____ Signature _____

Date _____/_____/_____ NPI _____ Order Date: _____/_____/_____

**Your signature confirms the accuracy of the information provided on this form*