PRISM HEALTH CARE SERVICES
MEDICAL SUPPLIES • RESPIRATORY EQUIPMENT

ENHANCED RESPIRATORY PROGRAM

BREAS VIVO 45 LS NON-INVASIVE VENTILATOR ORDER

Fax: 872-469-1673
Ph: 847-310-4730

PATIENT NAME | DATE OF BIRTH | ORDER DATE:

NON-INVASIVE PROGRAM SETTINGS

☐ PRESSURE SUPPORT WITH TARGET VOLUME + AE	☐ PRESSURE ASSIST CONTROL WITH TARGET VOLUME + AE	☐ MULTIPLE TREATMENT PROFILES: HIGH FLOW NASAL THERAPY/ MOUTHPIECE VENTILATION
PATIENT HT (IN)	PATIENT HT (IN)	FLOW (LPM)
TARGET VOLUME (ML)	TARGET VOLUME (ML)	OXYGEN BLEED-IN (LPM)
PS MAX	PS MAX	KEEP SPO2 (%)
PS MIN	PS MIN	☐ VOLUME MPV ☐ PRESSURE MPV
BACKUP BREATH RATE (BPM)	BREATH RATE (BPM)	Volume (ml)
BACKUP INSPIRATORY TIME(S)	INSPIRATORY TIME(S)	Pressure:
EPAP MAX	EPAP MAX	INSPIRATORY TIME (S):
EPAP MIN	EPAP MIN	
PRESSURE LIMIT	PRESSURE LIMIT	

COMFORT SETTINGS

- ☐ TITRATE RISE TIME, INSP. TRIGGER AND EXP. TRIGGER FOR PATIENT COMFORT
- ☐ +/- 100 ML VOLUME ADJUSTMENT (IF NEEDED)
- ☐ ADD HOME ADJUST SETTINGS

SUPPLEMENTAL OXYGEN

- ☐ ROOM AIR
- ☐ TITRATE OXYGEN TO MAINTAIN SaO2 _____
- ☐ FiO2 LPM _____

FREQUENCY- HOURS OF USE

☐ CONTINUOUS ☐ DURING SLEEP ☐ PRN PROVIDE PARAMETERS

MODALITY-MASK INTERFACE

☐ FIT TO COMFORT ☐ FULL FACE MASK ☐ NASAL MASK ☐ NASAL PILLOWS

HUMIDIFICATION

☐ HEATED ☐ NO HUMIDIFICATION WITH MOUTHPIECE VENTILATION

ADDITIONAL COMMENTS

PHYSICIAN INFORMATION

By my signature below, I authorize the use of this document as a dispensing prescription. I understand with respect to ordering non-invasive ventilation for this patient is a clinical decision made by me based on clinical needs, and my records concerning this patient support the medical necessity for the items prescribed.

Physician Printed Name:_____ NPI: _____

Physician Signature: _____ Signature Date: _____