PRISM HEALTH CARE SERVICES
MEDICAL SUPPLIES • RESPIRATORY EQUIPMENT

ENHANCED RESPIRATORY PROGRAM

RESMED ASTRAL 150 NON-INVASIVE VENTILATOR

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

PATIENT NAME | DATE OF BIRTH | ORDER DATE:

NON-INVASIVE PROGRAM SETTINGS

☐ IVAPS W/ SINGLE LIMB WITH LEAK	☐ PS W/ SINGLE LIMB WITH LEAK	☐ ST W/ SINGLE LIMB WITH LEAK	☐ MOUTHPIECE VENTILATION
CHECK ONE: ☐ IVAPS ☐ IVAPS AE	PATIENT HT (IN)	☐ PROGRAM FOR DESENSITIZATION OR DAY TIME SETTING	☐ ADJUST SETTINGS TO PATIENT TOLERANCE
PATIENT HT (IN)	EPAP/PEEP	PATIENT HT (IN)	SELECT MODE ☐ P(A)CV ☐ PS ☐ (A)CV
EPAP/PEEP	PS	IPAP	TI (0.20-5.0)
PS MIN	RR	EPAP	P CONTROL (2.0-50.0)
PS MAX		RR	RISE TIME (MIN-900)
TARGET RR			MANUAL BREATH (CHECK ONE) ☐ ON ☐ OFF
TIDAL VOLUME			RR (CHECK ONE) ☐ ON ☐ OFF

COMFORT SETTINGS

	TRIGGER	CYCLE
RISE TIME (MIN- 900)	☐ VERY LOW	☐ VERY LOW
TIMIN (0.10-4.00)	☐ LOW	☐ LOW
TIMAX (0.30-4.00)	☐ MEDIUM	☐ MEDIUM
	☐ HIGH	☐ HIGH
	☐ VERY HIGH	☐ VERY HIGH

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: _____