AdventHealth | Respiratory and Equipment

556 Florida Central Parkway, Suite 1060
Longwood, FL 32750
Phone: (407) 830-1938 • Fax: (407) 830-0936

3715 Lake Center Drive
Mount Dora, FL 32757
Phone: (352) 253-2326 • Fax: (407) 830-0936

Detailed Written Order (Non-Invasive Ventilation)

Patient Name:_____ Date of Birth: _____

Estimated Length of Need: (*Check One*): 99 Months (Lifetime) Or: _____

PLEASE ATTACH: Patient Demographics (including Height and Weight) and Signed Clinical Notes.

Please choose one (1) of the following therapy modes:

Therapy Mode One

☐ **BILEVEL with AVAPS**

Tidal Volume: _____ml
IPAP Max: _____cm H2O
IPAP Min: _____cm H2O
EPAP: _____cm H2O

Therapy Mode Two

☐ **BILEVEL S/T AVPS**

Tidal Volume: _____ml
IPAP Max: _____cm H2O
IPAP Min: _____cm H2O
EPAP: _____cm H2O

Therapy Mode Three

☐ **AVAPS - AE**

Tidal Volume: _____ml
Max Press: _____cm H2O
Press Support Max: _____cm H2O
Press Support Min: _____cm H2O
EPAP Max: _____cm H2O
EPAP Min: _____cm H2O
Breathe Rate: _____(Auto, Off, or 1-60)

Additional Settings

☐ **Oxygen Bleed In** _____LPM

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, ordered the above mentioned items.

Printed Physician Name: _____

NPI: _____

Date: _____

Physician Signature: _____

Signature Date:_____Time: _____

Patient Sticker