Non-Invasive Ventilator Prescription

Patient Name: _____DOB:_____MR#:_____

Address:_____

Preferred Contact #: _____Patient email:_____

Insurance:_____ID:_____

Diagnosis: ❑ ALS (G12.21); ❑Respiratory Failure (J96.90); ❑Motor Neuron Disease (G12.20); ❑Muscular Dystrophy (G71.0); ❑Primary Lateral Sclerosis (G12.29); ❑Other:_____

Length of Need: 99 **Date of face to face encounter**:___

❑ **Non Invasive Ventilator**

❑ST

IPAP:_____CM EPAP:_____CM

Back up rate:_____BPM

❑ST with Target Tidal Volume

EPAP: _____ CM IPAP MIN: _____ CM IPAP MAX: ____

Target VT: _____ ml Backup Rate: _____ BPM

❑ST with Target Tidal Volume with Auto-Epap

EPAP MIN: _____ CM EPAP MAX:____CM

PS MIN: _____ CM PS MAX: ____CM

Target VT: _____ ml

Backup Rate: _____ BPM

Humidification: ❑Heated humidification ❑HME

Patient interface: ❑Mask: fit per patient comfort ❑MPV

Hours of use: ❑Continuous

Download frequency: 6 weeks from start date, then every 3 months. Fax to:

Ordering Physician Name: _____

Ordering Physician Signature: _____

NPI:_____

Date:_____