RT Medical - Jenny: 615-469-7299 ext 114 RT Medical Fax: 615-469-7596

VENTILATOR and NON INVASIVE VENTILATOR REFERRAL FORM

Referral Source:

Referral name: _____ Order Date: _____

Phone:_____ Fax: _____

Patient Information:

Patient name: _____ DOB: _____

Home phone: _____ Mobile phone: _____

Delivery Address: Street _____ City_____ State_____ Zip_____

Ventilator is covered for: Severe neuromuscular or restrictive thoracic disease, and chronic respiratory failure consequent to severe chronic obstructive pulmonary disease.

Diagnosis ICD-10: _____

Please include all of the following documentation:

- ☐ Quarterly and PRN clinical assessments to include oximetry, breath sounds, oxygen titration, alarm adjustments
- ☐ Patient demographics and insurance information
- ☐ Face-to-face evaluation/hospital medical records within last 6 months (Respiratory ailment/medical history)
- ☐ For COPD patients ONLY, one of the following:
  - ☐ PCO2 >52 mmHg or FEV1 <50% of predicted, or,
  - ☐ PCO2 between 48-51 mmHg or FEV1 <51-60% of predicted AND have 2 or more respiratory-related hospital admissions w/i past 12 mo.
- ☐ For non-Medicare OHS patients ONLY, all of the following:
  - ☐ PCO2 >45 mmHg BMI >40
  - ☐ Diagnosis of obstructive sleep apnea (OSA)
- ☐ Reason for medical necessity, including why the patient needs pressure support ventilation due to severe and/or life threatening disease state, and the consequences if they patient does not receive the benefit of pressure support ventilation.
- ☐ If the patient was previously on bi-level with or without rate as an outpatient, indicate where Bi-level failed by ABG documentation.
- ☐ Other documentation, ONLY IF AVAILABLE:
  - ☐ For Neuromuscular patients, FVC or MIP/NIF test results
  - ☐ For Restrictive Thoracic patients, pCO2 or FVC test results
  - ☐ Last hospital admission/readmission.

Estimated length of need _____ months (99= lifetime) Patient Height: _____

Device Mode:

Volume Control	Pressure Control	AVAPS	Mouthpiece Ventilation

ONLY for Mouthpiece Ventilation: _____ ACV Mode: Ti_____ VT_____ // PACV Mode: Pcontrol_____ Ti_____

Device Settings:

PS Max	PS/PC/IPAP (Min)	VT	Ti	PEEP/EPAP	RR

OR Titrate to patient comfort _____

Please check all that apply:

Supplemental O2: _____ LPM, Does patient wear home O2?

Hours of Use: During Sleep _____ Continuous ____ (need back up ventilator)

Equipment Ordered:

Ventilator with related supplies ____, Heated Humidifier_____, NIV Face Mask_____ -OR- Trach Tube Size_____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering these items for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Physician name _____ **NPI #** _____

Physician Signature_____ **Date**_____