Hillrom™

PRESCRIPTION / ORDER FORM

Life2000® Ventilation System

Patient Name: _____
(Required - please print) First Middle Last

Birth Date: ____ / ____ / ____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

Facility Contact Person: _____
Phone: _____
E-mail: _____
Following Physician/PCP: _____
Phone: _____
E-mail: _____

Patient Contact Name: _____ Relationship to Patient: _____

Phone: _____ ☐H ☐C ☐W Alt Phone: _____ ☐H ☐C ☐W E-mail: _____

Date patient last seen: _____ Is the patient currently in the hospital? ☐N ☐Y Discharge Date: _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Relevant Medical History (check all that apply):

1. ☐ $pC0_2$ ≥48 mmHg ☐ FEV_1 ≤50% of predicted ☐ 2 or more respiratory related hospitalizations within the last year

2. Has bi-level been tried and failed, ruled out, or insufficient for patient needs? ☐ Yes ☐ No
   Please indicate reasons bi-level has been tried and failed, ruled out or insufficient for patient needs (check all that apply):
   - ☐ Unable to tolerate
   - ☐ Does not provide the level of ventilatory support to meet patient needs
   - ☐ Other
   - ☐ Patient will continue to use bi-level at night to treat sleep disorder breathing
   - ☐ Requires mobile ventilation

   Comments _____

Clinic Information: Fac#

_____
_____
_____
Phone:
Fax: _____

1. _____ Date of Signature (Required - MM/DD/YY)
2. _____ Prescriber's Signature (Required - no stamped signatures accepted)
3. _____ Print Prescriber's First and Last Name (Required)
4. _____ NPI Number (Required)

Please include documentation for a medical condition that supports the need for the device.

℞ Life2000® Ventilation System & Supplies HCPC=E0466

Please check the appropriate diagnosis and include the correlating ICD-10 code in the space provided:

☐ Chronic respiratory failure
_____(ICD-10 code)

☐ Chronic obstructive pulmonary disease
_____(ICD-10 code)

☐ Other
_____(description)
_____(ICD-10 code)

PROTOCOL

The Life2000® ventilator requires a 50 psi O2 cylinder to operate.

Length of need: 99 months=lifetime

Mode: Assist/Control	Sleep/ Rest/ Low Activity	Medium Activity	High Activity
Volume (50-750 mL)	150 mL	180 mL	200 mL
	X Check to allow adjustment within ±75 mL of volume for each activity level as needed to maintain SpO2 >90% and adequate ventilation.		
PEEP (0-10 cm H20)	0-5 cmH_2O		
BR (0-40 BPM)	10-12 BPM		
I-Time (0.15-3.00)	1.00 sec.		
Sensitivity (0-9, OFF)	4		
X Adjust to patient comfort for all Rxs			

☒ Titrate 02 at each activity level to maintain 02 saturation >90% or to _____ %

Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records