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 applicable boxes below)

*Please provide proper documentation from the patient's medical record which supports any of the relevant medical history indicated below. For patients with chronic respiratory failure consequent to COPD, both diagnoses must be included in the documentation.

☐ pCO_2 ≥52mmHg; or FEV_1 ≤50% of predicted; or HCO_{3-} ≥ 31 mmol/L; or $ETCO_2$ ≥48mm Hg for 5 minutes or more during a test lasting at least 2 hours in duration; OR

☐ pCO_2 between 48-51mmHg or FEV_1 ≤51–60% of predicted obtained AND have 2 or more respiratory-related hospital admissions within the past 12 months

☐ Medical necessity for pressure support ventilation including, but not limited to, progress of the patient's disease state, prior treatment results and current treatment plans

☐ Patient previously tried and failed bi-level or bi-level was considered and not sufficient for the patient to meet medical need

Comments:

Clinic Information:

_____
_____
_____
Phone:
_____

1. _____ Signature Date (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**

_____ Primary Diagnosis

_____ Primary Diagnosis Code

_____ Secondary Diagnosis

_____ Secondary Diagnosis 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