Home Medical Equipment and Oxygen
450 State Route 664 North • P.O. Box 997 • Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 •FAX: (740) 385-0474
242 W. 6th Ave. • Lancaster, Ohio 43130
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MECHANICAL VENTILATION ORDER FORM

_____Initial Order _____Renewal Order Date of Order:______________________

Patient:____DOB:_______________________

Physician:____UPIN:________________

Address:____

Primary Respiratory Diagnosis:____
____

Complicating Factors:____
____

Airway/Application:____Non-invasive; Type:___________________
____Invasive; Trach Tube Size and Type:____________________________________
(See Trach Care Order Sheet)

_____This patient requires mechanical ventilation 24 hours per day. _____Patient requires mechanical ventilation _____ per day for these indications:____
____

_____Back-up _____Alternate ventilator is indicated for this patient:
_____Total ventilatory support required _____Response time for replacement ventilator would typically be over two hours.

Ventilator Settings: Mode: ____Control ____Assist/Control ____SIMV ____Pressure Support

Settings: Rate_______ V/T_______SIMV_______ Pressure Support____________________

____Pressure Control ____Volume Control

Alarm Settings: High Pressure:____

Low Pressure:____
Is Supplemental Oxygen Ordered: ____Yes ____No, FI02 _____; ____"Bleed-in" ____Blender
Additional Settings or Instructions:____
____
Length of Need: ____3 Months ____6 Months ____Lifetime

Physician Signature:____Date_________________