VOCSN

Multi-Function Ventilator

HCPCS E0467

[Click to add your logo.]

Name:
Address:
Phone/Email:
Fax:

Noninvasive Ventilation Prescription

Patient Information

Name:			Date:
DOB:	MRN:		Length of Need:
Primary Dx:	ICD-10:	Secondary Dx:	ICD-10:

Please attach patient demographics, copy of insurance card & additional documentation as required.

VOCSN Multi-Function Ventilator ☐ Check to prescribe*

*Requires a prescription for ventilation + one other therapy

Ventilation

Notes:

☐ **Mouthpiece Ventilation**

Hours of Use: ☐ Nocturnal ☐ Daytime ☐ Continuous
Interface: ☐ Patient Comfort ☐ Other:

Mode: ☐ Spontaneous ☐ AC-Pressure ☐ AC-Volume
Settings: ☐ Titrate Patient Comfort and/or ☐ Tidal Volume: or ☐ Pressure: ☐ Flow Trigger:

☐ **Volume Targeted Ventilation**

Hours of Use: ☐ Nocturnal ☐ Daytime ☐ Continuous
Interface: ☐ Mask ☐ Other:

Mode: ☐ Vol. Targeted-PS (AVAPS/PVRS) ☐ Vol. Targeted-PC (PRVC) ☐ Vol. Targeted-SIMV (SIMV+PRVC)
Settings: ☐ Titrate Patient Comfort and/or

☐ Pres. Minimum:	☐ Pres. Adj. Rate:	☐ High Pres. Alarm:	☐ Tidal Volume:
☐ BR:	☐ IT:	☐ PEEP:	☐ Rise Time:
☐ Flow Trigger:	☐ Flow Cycle:	☐ Time Cycle:	☐ Apnea Rate:

☐ **Bi-Level Ventilation**

Hours of Use: ☐ Nocturnal ☐ Daytime ☐ Continuous
Interface: ☐ Mask ☐ Other: **Mode:** ☐ Bi-Level (S/T and T)

Settings: ☐ Titrate Patient Comfort and/or

☐ BR:	☐ IT:	☐ EPAP:	☐ IPAP:	☐ Apnea Rate:
☐ Flow Trigger:	☐ Flow Cycle:	☐ Time Cycle:	☐ Rise Time:	

Additional Ventilation Prescriptions:
☐ Heated Humidifier (E0562) with all required supplies ☐ Heat-Moisture Exchanger (HME)
☐ Patient is wheelchair dependent and requires a second ventilator (one mounted to wheelchair for daytime mobility, and one bedside for nocturnal use). Provide detail:

Oxygen ☐ Check to prescribe

Notes:

☐ 6 L/min Equivalent Internal Concentrator (1-6 L/min):
☐ 1-10 L/min bled in externally:
☐ External High-Pressure Oxygen (21-100% FiO2):

Cough ☐ Check to prescribe

Notes:

Frequency: ☐ BID ☐ PRN ☐ Other: **Interface:** ☐ Mask ☐ Mouthpiece ☐ Other:
☐ Titrate to achieve an effective cough, or
☐ Inspiratory Pressure: ☐ Expiratory Pressure:

Suction ☐ Check to prescribe

Notes:

☐ Oral suction as needed to clear secretions ☐ Other:

Nebulizer ☐ Check to prescribe

Notes:

Medication: **Frequency:**

Prescribing Physician

Name:		Signature:
NPI:	Phone:	Date:

CAUTION: Please refer to the VOCSN Clinical and Technical Manual for detailed instructions, including indications and contraindications for use. Once it has been determined that VOCSN is clinically appropriate, please use this prescription template as a guide. MKT-00011 Rev B

VOCSN

Multi-Function Ventilator

HCPCS E0467

[Click to add your logo.]

Name:
Address:
Phone/Email:
Fax:

Invasive Ventilation Prescription

Patient Information			
Name:			Date:
DOB:	MRN:		Length of Need:
Primary Dx:	ICD-10:	Secondary Dx:	ICD-10:

Please attach patient demographics, copy of insurance card & additional documentation as required.

VOCSN Multi-Function Ventilator ☐ **Check to prescribe*** *Requires a prescription for ventilation + one other therapy

Ventilation

Notes:

☐ **Invasive Ventilation**

Hours of Use: ☐ Nocturnal ☐ Daytime ☐ Continuous

Interface: ☐ Trach ☐ Other:

Mode: ☐ AC-Pressure (PC) ☐ AC-Volume (VC and CV)
☐ SIMV-Pressure ☐ SIMV-Volume (SIMV modes include S, Pressure Support, and CPAP)
☐ Vol. Targeted-PS (AVAPS/PVRS) ☐ Vol. Targeted-PC (PRVC) ☐ Vol. Targeted-SIMV (SIMV+PRVC)

Settings: ☐ Titrate Patient Comfort and/or

☐ Pres. Minimum:	☐ Pres. Adj. Rate:	☐ High Pres. Alarm:	☐ Tidal Volume:
☐ BR:	☐ IT:	☐ PEEP:	☐ Pres. Control:
☐ Pres. Support:	☐ PC Flow Term:	☐ Rise Time:	☐ Sigh:
☐ Flow Trigger:	☐ Flow Cycle:	☐ Time Cycle:	☐ Apnea Rate:

Additional Ventilation Prescriptions:

☐ Heated Humidifier (E0562) with all required supplies ☐ Heat-Moisture Exchanger (HME)
☐ Patient is wheelchair dependent and requires a second ventilator (one mounted to wheelchair for daytime mobility, and one bedside for nocturnal use). Provide detail:

Oxygen ☐ Check to prescribe

Notes:

☐ 6 L/min Equivalent Internal Concentrator (1-6 L/min):
☐ 1-10 L/min bled in externally:
☐ External High-Pressure Oxygen (21-100% FiO2):

Cough ☐ Check to prescribe

Notes:

Frequency: ☐ BID ☐ PRN ☐ Other: **Interface:** ☐ Mask ☐ Mouthpiece ☐ Trach ☐ Other:
☐ Titrate to achieve an effective cough, or
☐ Inspiratory Pressure: ☐ Expiratory Pressure:

Suction ☐ Check to prescribe

Notes:

☐ Tracheal and/or oral suction as needed to clear secretions ☐ Other:

Nebulizer ☐ Check to prescribe

Notes:

Medication: **Frequency:**

Prescribing Physician		
Name:		Signature:
NPI:	Phone:	Date:

CAUTION: Please refer to the VOCSN Clinical and Technical Manual for detailed instructions, including indications and contraindications for use. Once it has been determined that VOCSN is clinically appropriate, please use this prescription template as a guide. MKT-00011 Rev B