BiPAP® / CPAP ORDER

CHILD SUMMARY

Diagnosis ______________________ Height __________ Weight __________

Respiratory infectious process ☐ MRSA ☐ Other ______________________

EQUIPMENT / SUPPLY NEEDS

☐ Full face mask ☐ Nasal mask ☐ Nasal pillows ☐ Oxygen concentrator – quantity ________

☐ SVN machine and in-line valved T-adapter ☐ Humidification: ☐ Cool ☐ Heated ☐ Back-up battery

☐ Other ______________________

PHYSICIAN / PRACTITIONER ORDERS (Do not leave blanks. Use "N/A" when not applicable.)

BiPap® (Bi-level) or CPAP Non-invasive positive pressure ventilation NPPV

☐ Intermittent ☐ Continuous (use of > 12 hours/day)

BiPap® settings

IPAP (inspiratory pressure) ______________ EPAP (expiratory pressure) ______________

Mode (S-spontaneous or S/T spontaneous/times) __________ Back-up rate (only needed if in S/T mode) __________

O_2 bleed-in ______________ LPM ______________

CPAP settings

cm H_20 ________ O_2 bleed-in ________ LPM ________ Hours child to be on CPAP ________

CPT settings ________ Cycles ________ Frequency ________

Cough assist settings ________ Cycles ________ Frequency ________

FAX to Ryan House at 602.266.0911

T/O or V/O from Physician / Practitioner (print) ______________________

To Nurse (print) ______________________

Date ______________ Time ______________

Physician / Practitioner fax ______________________

Physician / Practitioner signature ______________________ Date __________

Physician / Practitioner: Please sign and fax within 72 hours to Ryan House at 602.266.0911

Your signature indicates approval of the orders

Nurse Signature ______________________ Employee ID __________

Child Name ______________________ Child ID __________ Date __________

ORIGINAL: Send for Signature then Medical Records **YELLOW:** Patient Chart