ASTRAL 100/150 FOR COPD LMN

Date: _____

Patient Name: _____ DOB: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

❑ **iVAPS** ❑ **with Auto EPAP**	❑ **PS with Safety Tidal Volume**	❑ **S/T**
Avg. Vt _____mL	PS _____cmH20	IPAP _____cmH20
Target Rate _____/min	PEEP _____cmH20	EPAP _____cmH20
EPAP (fixed) _____cmH20	Resp. Rate _____/min	Resp. Rate _____/min
Auto EPAP ____ to ____ cmH20	Safety Vt _____mL	Safety Vt _____mL (optional)
Min PS _____cmH20	PS Max _____cmH20	IPAP Max _____cmH20
Max PS _____cmH20		

SUPPLEMENTAL OXYGEN: ____ L/min Titrate 02 for Sp02 _____% Duration_____ Sp02 results_____%

HUMIDIFICATION: ❑ Heated (E0562)

PATIENT INTERFACE: ❑ Mask ❑ Trach tube ❑ MPV **FREQUENCY:** ❑ Every three months

DOWNLOAD REPORTS: ❑ Yes ❑ No Download frequency:_____

REMOTE MONITORING IN AIRVIEW: Give access to provider: ❑ Yes ❑ No

DIAGNOSIS: _____

HOURS OF USE: ❑Continuous ❑Other: _____

DURATION OF USE: ❑Lifetime/99 years ❑Other_____

ADDITIONAL ORDERS: _____

PHYSCIAN INFORMATION

Referring MD: _____ Phone:_____ FAX:_____

Ordering MD: _____ Phone:_____ FAX:_____

ORDERING PHYSICIAN'S SIGNATURE: _____ Date:_____

NPI:_____

support@reliablerespiratory.com

PLEASE SIGN AND FAX TO 781-987-8206