VENTILATOR ORDER

CHILD SUMMARY

Diagnosis ______________________ Height ______________ Weight ______________

Respiratory infectious process ☐ MRSA ☐ Other ______________________________

EQUIPMENT / SUPPLY NEEDS

☐ Humidification for ventilator ☐ O_2 concentrator ☐ SVN machine and in-line valved T-adapter ☐ Aerosol setup

☐ T-piece / Trach collar ☐ Suction machine(s) will be used for (check all that apply): ☐ Oral ☐ Tracheal

☐ Other ______________________________

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

Ventilator / Information

Date trached ______________________ Trach size ______________________

Trach manufacturer and type ______________________________

Helpful hints for managing your child's airway ______________________________

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Settings

Mode (SIMV, A/C) ______________ Rate setting (RR) ______________ Tidal volume (TV) ______________

Pressure support (PSV) ______________ Pressure control ______________ Peak inspiratory pressure (PIP) ______________

O2 bleed-in ______________ LPM PEEP ______________________________

Helpful hints for managing your child's airway ______________________________

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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 ______________