



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) _____

O₂ bleed-in _____ LPM _____

CPAP settings

cm H₂O _____ O₂ 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 _____