Maverick Oxygen & Respiratory Equipment, LLC

Advanced Pap Order Form

For BiPAP AVAPS and VPAP ST-A

Fax to 502-225-0605

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Step 1: Complete the box below corresponding to your desired equipment:

Respironics BiPAP AVAPS:

Vt: _____ml Respiratory Rate: _____ IPAP min: _____ IPAP max: _____ EPAP: _____

I-time: _____ Rise time: _____

OR

Resmed VPAP ST-A

EPAP: _____ Target VA: _____ml/kg Target Rate: _____ Min PS: _____ Max PS: _____

Ti-Max: _____ Ti-Min: _____ Patient Height: _____inches

Step 2: Check the boxes corresponding to additional equipment requested:

Nasal Mask	**Interface/Mask:**	Full Face Mask
☐ Small	Select both mask	☐ Small
☐ Medium	style and size	☐ Medium
☐ Large		☐ Large

Step 3: Fill out the following information in its entirety and fax to us- There is a 3pm EST. cut-off for next day delivery.

Patient Name: _____Room #: _____

Facility Name: _____Contact Name: _____

Contact Phone #: _____ Contact Email: _____

Shipping Address _____

Please Note: The box that corresponds with the requested ventilation mode must be filled out in its entirety. A single blank space will prohibit the setting of the machine, delay your order and require you to consult with the practitioner for complete settings.

Form: MAVAVDPAPORD2017