



**Maverick  
Oxygen &  
Respiratory  
Equipment, LLC**

## **Trilogy/BiPAP V30 Ventilator**

### **Order Form**

**FAX TO 502-225-4772**

**Step 1: Complete the box below corresponding to your desired ventilation mode:**

While both units have AVAPS-AE available, the BiPAP V30 has a max pressure limit of 30cm H2O while the Trilogy100 has a max pressure limit of 50cm H2O

#### **AVAPS- AE Mode:**

Vt: \_\_\_\_\_ml    Respiratory Rate: \_\_\_\_\_    PS min: \_\_\_\_\_    PS max: \_\_\_\_\_    EPAP min: \_\_\_\_\_  
EPAP max: \_\_\_\_\_    AVAPS rate: (Circle One) **1 2 3 4 5**    Max pressure: \_\_\_\_\_    I-Time \_\_\_\_\_

**OR**

#### **ST W/ AVAPS**

Vt: \_\_\_\_\_ml    Respiratory Rate: \_\_\_\_\_    IPAP Min: \_\_\_\_\_    IPAP Max: \_\_\_\_\_    EPAP \_\_\_\_\_    Rise Time \_\_\_\_\_  
AVAPS Rate: (Circle One) **1 2 3 4 5**

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

#### **Humidification:**

Check box if heated humidification required:

☐ Heated Humidifier

#### Nasal Mask

- ☐ Small  
☐ Medium  
☐ Large

#### **Interface/Mask:**

Select both mask  
style and size

#### Full Face Mask

- ☐ Small  
☐ Medium  
☐ 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 may prohibit the setting of the machine, delay your order and require you to consult with the practitioner for complete settings.**