AVAPS Order Slip

MasVidaHealth™ CARE SOLUTIONS
133 Nursery Lane, Fort Worth, TX 76114
Customer Success: 1-877-790-5994
Fax: 1-817-890-9098

YOUDONOTNEEDTOFILLOUTTHISFORMIFYOUALREADY HAVE A PRESCRIPTION FROM THE PATIENT's PHYSICIAN. PLEASE SKIPTOTHEBOTTOMANDREADOURSUBMISSION PROCESS IF YOU ALREADY HAVE A PRESCRIPTION.

Facility Information:				
Name:	Address:	City:	State:	ZIP:

Patient Information:		
First:	Last:	Room #:

☐ **Option 1: Complete if MasVida IS Programming the equipment.**

ONLY CHOOSE ONE OPTION

Please ONLY check one of the options below:

☐ 1. Mode BiPAP S/T with AVAPS		☐ 2. Mode BiPAP with AVAPS		☐ 3. Mode AVAPS AE	
Tidal Volume		Tidal Volume		Tidal Volume	
iPAP Max Pressure		iPAP Max Pressure		Max Pressure (If Prescribed)	
iPAP Min Pressure		iPAP Min Pressure		Pressure Support Max	
EPAP		EPAP		Pressure Support Min	
Respiratory Rate				EPAP Max	
				EPAP Min	
				Breath Rate	
Comfort Settings: Circle one from each		Comfort Settings: Circle one from each		Comfort Settings: Circle one from each	
AVAPS Rate	1 2 3 4	AVAPS Rate	1 2 3 4	AVAPS Rate	1 2 3 4
1-Time	0.8 0.1	1-Time	0.8 0.1	1-Time	0.8 0.1
Rise Time	3 4	Rise Time	3 4	Rise Time	3 4

Also fill out the below settings:

DO YOU NEED CONCENTRATOR? ☐ YES ☐ NO	%FI02:	Heated Humification: ☐ YES ☐ NO

Print Clinician Name & Credentials			*Clinician Signature*			*Print Prescribing Physician Name*	
First:	Last:	Credentials:	Sign here:	Date: / /	Time:	First:	Last:

Make your mask selection: CHOOSE ONLY ONE:

☐ 1. Trach Connection	☐ 2. Full Face Mask	☐ 3. Nasal Mask	☐ 4. Nasal Pillows
	Circle One: XLG / Large / Medium / Small	**Circle One:** Large / Medium / Small	

☐ **Option 2: Complete if MasVida IS NOT Programming the equipment.**

Clinician name/ Credentials			*Clinician signature*		
First:	Last:	Credentials:	Sign here:	Date: / /	Time:

Form Submission Process

FAX to **817-890-9098**