Intus Healthcare Ltd
2 Walton Business Centre
46 Terrace Road
Walton-on-Thames
Surrey KT12 2SD
United Kingdom

T: 0800 024 8050 / E: Contact@IntusHealthcare.eu
F: 0844 504 9494 / W: IntusHealthcare.eu

Confirmation of BiLevel (BiPAP) requirement

ATTENTION CLINICIAN: This patient would like to purchase BiLevel equipment from Intus Healthcare. We do not currently have their prescription on file and require it before we can send the equipment to them. Please complete the details below and return it to Intus Healthcare by email to **contact@intushealthcare.eu** or by fax to **0844 504 9494**.

Patient Information:

Name: _____ Gender: ☐ Male ☐ Female

Address: _____

_____

_____

Postcode: _____ D.O.B.: _____/_____/_____

I confirm that the above patient requires the following BiLevel therapy equipment:

☐ **Fixed BiLevel** Mode: ☐ S ☐ S/T ☐ T
EPAP: _____ cmH_2O IPAP: _____ cmH_2O
Ramp time: _____ mins Ramp start pressure: _____ cmH_2O
S/T or T mode settings (N/A for S mode):
Ti: _____ seconds (0.5-3) BMP: _____(0-30)

☐ **Auto BiLevel** Mode: ☐ S ☐ S/T ☐ T
Min EPAP: _____ cmH_2O Max IPAP: _____ cmH_2O
Min PS: _____ cmH_2O *(optional)* Max PS: _____ cmH_2O *(optional)*
Ramp time: _____ mins Ramp start pressure: _____ cmH_2O
S/T or T mode settings (N/A for S mode):
Ti: _____ seconds (0.5-3) BMP: _____ (0-30)

☐ **Mask** ☐ Full Face ☐ Nasal ☐ Other (please specify) _____

Clinician Information:

Name: _____

Title: _____

Hospital or Clinic: _____

Telephone: _____ Email: _____

Signature: _____ Date: _____