



Important

Please open this form in Adobe Acrobat.
It has interactive elements which may not function correctly
if opened in your web browser.

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<https://get.adobe.com/reader/>

Bivona™ Customized Adjustable Flange Tracheostomy Tube Template

1. Shaft Length

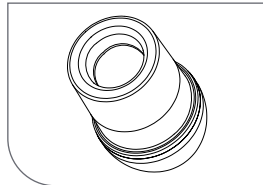
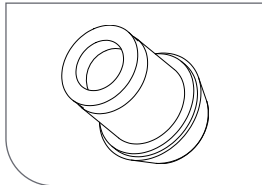
Shaft Length _____ mm (30 mm min, 200 mm max)

2. Shaft

I.D.	O.D.	I.D.	O.D.	I.D.	O.D.	I.D.	O.D.	I.D.	O.D.
<input type="radio"/> 2.5	4.0	<input type="radio"/> 4.0	6.0	<input type="radio"/> 5.5	8.0	<input type="radio"/> 7.0	10.0	<input type="radio"/> 8.5	11.8
<input type="radio"/> 3.0	4.7	<input type="radio"/> 4.5	6.7	<input type="radio"/> 6.0	8.7	<input type="radio"/> 7.5	10.4	<input type="radio"/> 9.0	12.3
<input type="radio"/> 3.5	5.3	<input type="radio"/> 5.0	7.3	<input type="radio"/> 6.5	9.4	<input type="radio"/> 8.0	11.0	<input type="radio"/> 9.5	13.3

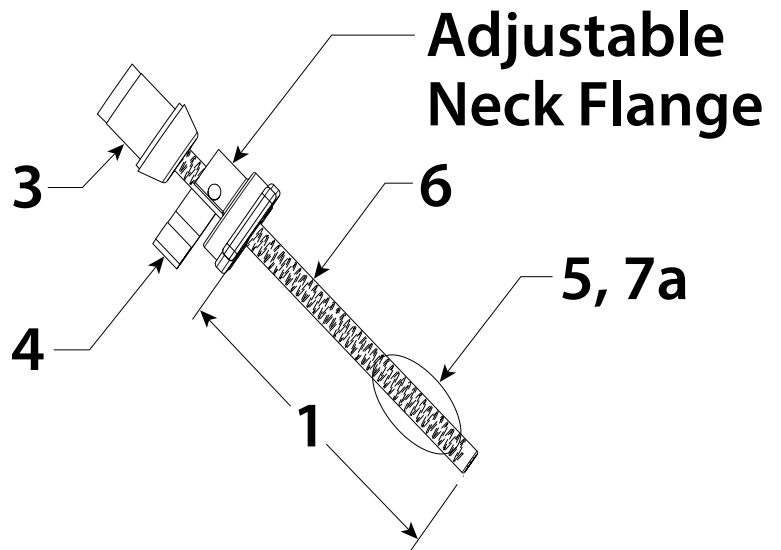
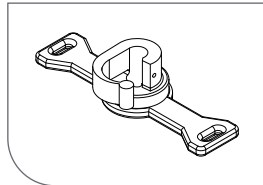
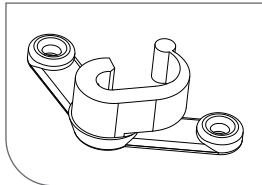
3. Connector (check one box only)

3a. Swivel 2.5–9.5 mm 3b. Fixed 2.5–6.0 mm



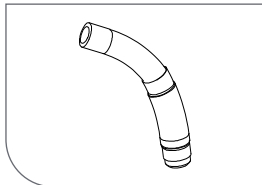
4. Neck Flange (check one box only)

4a. 2.5–5.5 mm 4c. 6.0–9.5 mm

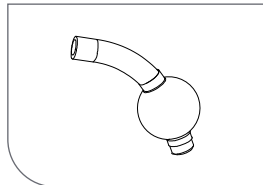


5. Cuff (check one box only)

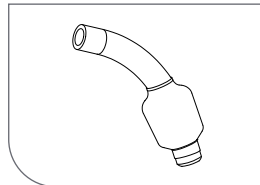
5a. TTS Tight to Shaft 5b. Air-Cufe™ Pedi 5b. Aire-Cuf Adult



2.5–9.5 mm



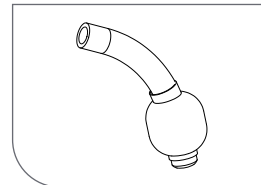
2.5–5.5 mm



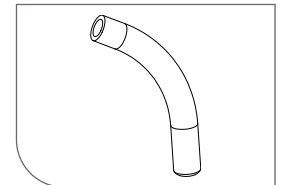
5.0–9.5 mm

5c. Fome-Cuf™ Adult

5d. Cuffless



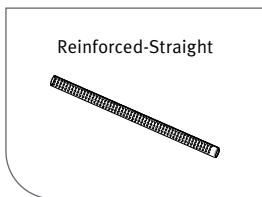
2.5–9.5 mm



2.5–9.5 mm

6. Shaft Option

6a. Hyperflex™



2.5–9.5 mm

Not intended for long term use.

This tube provides temporary airway access for a tracheostomized patient when determining the optimal tube length for the patient. This tube must be replaced with a fixed neck flange tracheostomy tube when the optimal length is determined.

7. Optional

7a. Distal (Bottom) Cuff

Cuff distance from tip to shaft _____ mm

Note: Cuff distance from tip cannot be less than the minimum standard distance listed below:

- a. Pediatric TTS, Aire-Cuf & Fome-Cuf – 3 mm
- b. Adult Aire-Cuf & Fome-Cuf – 5 mm
- c. Adult TTS – 9 mm

8. Approval Please note: ICU Medical will review the completed template for compliance.

Any required modifications will be made with the approval of a clinician.

Hospital/Clinic _____

Clinician Name _____ Clinician Title _____

P.O. Number _____ Date _____

9. Select Type of Service

Extended next day service (non-sterile), same day shipping if order received by 12 noon (CST) USA only

Standard service (sterile)

Express service (non-sterile)

Standard service (non-sterile)

Next day service (non-sterile) USA only