Vest therapy prescription/assessment form

RespirTech®

Fax to 800.962.1611 Questions? Call 800.793.1261

REQUIRED ATTACHMENTS: Patient demographic sheet | Copy of insurance card | Medical records

Patient information

Order date _____

Name (last) _____ (First) _____ M ☐ F ☐

Date of birth _____ Phone _____

Notes _____ Medical record # _____

Patient measurements: Chest _____ inches *(Measure fullest part of chest, at nipple line)* Abdomen _____ inches *(Measure largest circumference of abdomen while sitting)* Vest color _____

Healthcare facility _____ Phone _____ Fax _____ Anticipated discharge date, if currently hospitalized _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Medical necessity assessment: *This information must be supported in the patient's medical record and a copy of the record must accompany this prescription.*

Airway clearance therapies tried and/or considered *(Check all that apply)*

- ☐ Acapella/flutter/PEP
- ☐ Autogenic drainage
- ☐ Huff cough
- ☐ CoughAssist
- ☐ CPT (manual or percussor)
- ☐ Other _____

Reasons why the therapy failed, is contraindicated or inappropriate *(Check all that apply)*

- ☐ Artificial airway
- ☐ Arthritis/osteoporosis
- ☐ Aspiration risk/GERD
- ☐ Did not mobilize secretions
- ☐ Insufficient expiratory force
- ☐ Resistance to therapy
- ☐ Scoliosis/rod placement
- ☐ Spasticity/contractures
- ☐ Too fragile for percussion
- ☐ Unable to form mouth seal
- ☐ Other _____

Complete for bronchiectasis patients

Medical history in the past 12 months, unless otherwise indicated *(Check all that apply)*

- ☐ 3 or more exacerbations requiring antibiotics
- ☐ Daily productive cough for at least 6 months

- ☐ CT scan confirming diagnosis

OR

- ☐ Statement in medical record *(e.g., "CT on 01/01/2009 confirms bronchiectasis")*

Rx: High frequency chest wall oscillation device (HFCWO) (HCPCS:E0483)

Check length of need *(Only check one option)*: ☐ **Lifetime (99)** ☐ Other _____ *(If selected, must indicate # of months)*

☐ *Please check box if nebulizer therapy is to be used in conjunction with HFCWO*

Diagnoses: *(List all primary, secondary and underlying pulmonary, neurologic and other myopathy diagnoses that apply.)*

1. _____ (Code) _____ 3. _____ (Code) _____
2. _____ (Code) _____ 4. _____ (Code) _____

Quick start protocol (recommended):
Tx/day: 2 | Minutes/Tx: 30 | Frequencies: 6-15Hz | Pressure: 60-100% (or as tolerated by patient) | Minimum usage/day: 10 minutes

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for HFCWO from RespirTech, which, according to my professional judgment, is medically necessary for the patient identified above. The patient's record contains documentation supporting use of HFCWO. I agree to provide such documentation to RespirTech and/or its authorized agents upon request. A copy of this order will be retained as part of the patient's medical record.

Practitioner signature _____ Date _____

(Original signature and date required, stamped signature and date not accepted.)

Practitioner name (print) _____ NPI *(required)* _____

RespirTech personnel may fill in practitioner name and NPI prior to practitioner signature and date.

Custom protocol
(If other than recommended)
Tx/day _____ Minutes/tx _____
Frequencies _____ Pressure _____

☐ Check box if you would like a 30-day evaluation

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