

# Vest Therapy Prescription/Assessment Form (CA)



Fax to 800.962.1611 Questions? Call 800.793.1261

**REQUIRED ATTACHMENTS:** Patient Demographic/Face Sheet | Copy of Insurance Card | Medical Records

## Patient Information

Name (Last)  (First)  M ☐ F ☐  
Date of Birth  Order Date  Phone   
Notes   
**Patient Measurements:** Chest  inches (Measure fullest part of chest, at nipple line) Abdomen  inches (Measure largest circumference of abdomen while sitting)

**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
- ☐ Breathing techniques/huff cough
- ☐ Cough Assist
- ☐ 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
- ☐ No Skilled Caregiver Available
- ☐ Resistance to Therapy
- ☐ Scoliosis/Rod Placement
- ☐ Spasticity/Contractures
- ☐ Too Fragile for Percussion
- ☐ Unable to Form Mouth Seal
- ☐ Other

### 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

### Complete for Bronchiectasis Patients

- ☐ CT Scan Confirming Diagnosis OR
- ☐ Statement in Medical Record (i.e., "CT on 01/01/2009 confirms Bronchiectasis")

**Rx:** inCourage® Airway Clearance Therapy (HCPCS: E0483) Length of Need: Lifetime (99)

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

1.  (Code)
2.  (Code)
3.  (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 that the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for inCourage® Airway Clearance Therapy from RespirTech, which, according to my professional judgment, is medically necessary for the patient identified above. The patient's record contains documentation that supports use of the inCourage® Airway Clearance Therapy. 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.

Physician Signature (stamped signature not accepted)  Date (stamped date not accepted)

Physician Name (print)  NPI (required)

Health Care Facility Contact Name  Phone  Fax

Health Care Facility  City/State  Zip Code

### Custom Protocol

(If other than recommended)

Tx/Day

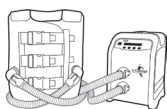
Minutes/Tx

Frequencies

Pressure

☐ Please check box if you would like a 30-Day\* Evaluation

\*Unless required by Payer



**RespirTech®**

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