# 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")*

## ℞: 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) _____ 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 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_____

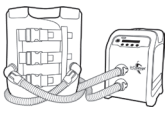
Minutes/Tx_____

Frequencies_____

Pressure_____

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

*Unless required by Payer



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