

Vest Therapy Prescription/Assessment Form

RespirTech®

Fax to 800.962.1611 Questions? Call 800.793.1261

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

➔ Patient Information	Order Date _____
Name (Last) <input style="width:250px;" type="text"/> (First) <input style="width:250px;" type="text"/> M <input type="checkbox"/> F <input type="checkbox"/>	
Date of Birth _____ Phone _____	
Notes _____	
Patient Measurements: Chest _____ inches (Measure fullest part of chest, at nipple line) Abdomen _____ inches (Measure largest circumference of abdomen while sitting) Vest Color _____	

Health Care Facility _____	Phone _____	Anticipated discharge date, if currently hospitalized _____
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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 <i>(Check all that apply)</i> <ul style="list-style-type: none"> <input type="checkbox"/> Acapella/Flutter/PEP <input type="checkbox"/> Autogenic drainage <input type="checkbox"/> Breathing techniques/huff cough <input type="checkbox"/> Cough Assist <input type="checkbox"/> CPT (Manual or Percussor) <input type="checkbox"/> Other _____ 	Reasons why the therapy failed, is contraindicated or inappropriate <i>(Check all that apply)</i> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Artificial Airway</td> <td><input type="checkbox"/> Resistance to Therapy</td> </tr> <tr> <td><input type="checkbox"/> Arthritis/Osteoporosis</td> <td><input type="checkbox"/> Scoliosis/Rod Placement</td> </tr> <tr> <td><input type="checkbox"/> Aspiration Risk/GERD</td> <td><input type="checkbox"/> Spasticity/Contractures</td> </tr> <tr> <td><input type="checkbox"/> Did Not Mobilize Secretions</td> <td><input type="checkbox"/> Too Fragile for Percussion</td> </tr> <tr> <td><input type="checkbox"/> Insufficient Expiratory Force</td> <td><input type="checkbox"/> Unable to Form Mouth Seal</td> </tr> <tr> <td><input type="checkbox"/> No Skilled Caregiver Available</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Artificial Airway	<input type="checkbox"/> Resistance to Therapy	<input type="checkbox"/> Arthritis/Osteoporosis	<input type="checkbox"/> Scoliosis/Rod Placement	<input type="checkbox"/> Aspiration Risk/GERD	<input type="checkbox"/> Spasticity/Contractures	<input type="checkbox"/> Did Not Mobilize Secretions	<input type="checkbox"/> Too Fragile for Percussion	<input type="checkbox"/> Insufficient Expiratory Force	<input type="checkbox"/> Unable to Form Mouth Seal	<input type="checkbox"/> No Skilled Caregiver Available	<input type="checkbox"/> Other _____	Medical history in the past 12 months, unless otherwise indicated <i>(Check all that apply)</i> <ul style="list-style-type: none"> <input type="checkbox"/> 3 or More Exacerbations Requiring Antibiotics <input type="checkbox"/> Daily Productive Cough for at Least 6 Months Complete for Bronchiectasis Patients <ul style="list-style-type: none"> <input type="checkbox"/> CT Scan Confirming Diagnosis <li style="text-align: center;">OR <input type="checkbox"/> Statement in Medical Record (e.g., "CT on 01/01/2009 confirms Bronchiectasis")
<input type="checkbox"/> Artificial Airway	<input type="checkbox"/> Resistance to Therapy													
<input type="checkbox"/> Arthritis/Osteoporosis	<input type="checkbox"/> Scoliosis/Rod Placement													
<input type="checkbox"/> Aspiration Risk/GERD	<input type="checkbox"/> Spasticity/Contractures													
<input type="checkbox"/> Did Not Mobilize Secretions	<input type="checkbox"/> Too Fragile for Percussion													
<input type="checkbox"/> Insufficient Expiratory Force	<input type="checkbox"/> Unable to Form Mouth Seal													
<input type="checkbox"/> No Skilled Caregiver Available	<input type="checkbox"/> Other _____													

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 patient 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. <input style="width:150px;" type="text"/> (Code) <input style="width:80px;" type="text"/>	3. <input style="width:150px;" type="text"/> (Code) <input style="width:80px;" type="text"/>
2. <input style="width:150px;" type="text"/> (Code) <input style="width:80px;" type="text"/>	4. <input style="width:150px;" type="text"/> (Code) <input style="width:80px;" type="text"/>

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 HFCWO 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 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.

<input style="width:350px; height: 30px;" type="text"/> Physician Signature <i>(Original signature and date required, stamped signature and date not accepted.)</i>	<input style="width:100px; height: 30px;" type="text"/> Date	Custom Protocol (If other than recommended) Tx/Day _____ Minutes/Tx _____ Frequencies _____ Pressure _____
<input style="width:350px; height: 30px;" type="text"/> Physician Name (print)	<input style="width:100px; height: 30px;" type="text"/> NPI <i>(required)</i>	<input type="checkbox"/> Check box if you would like a 30-day evaluation

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