



PRESCRIPTION / ORDER FORM

Phone 800.426.4224 Fax to: 1.800.870.8452

REQUIRED ATTACHMENTS: Patient Demographics, Copy of Insurance Card, Medical Records, and Face to Face Encounter Documents.

Brand Name Check One Box (Required)
The Vest Airway Clearance System
The VisiVest Airway Clearance System
Chest Measurement:
Garment Style: C3 VEST (Color:) / WRAP VEST / CHEST VEST
Monarch Airway Clearance System Including Battery
Mobile HFCWO device with wireless connectivity to the VisiView Health Portal.

Facility Contact: Phone: Email: Primary Language:

Patient Name: (Required - please print) First Middle Last
Language:

Patient Address: Street City State Zip

Birth Date: / / Gender: M F Medicaid ID # (if applicable):

Patient Contact Name & Relationship:

Phone: H C W Alt Phone: H C W E-mail:

Last Face to Face Encounter: Is the patient currently in the hospital? N Y Discharge Date:

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)

Please indicate methods of airway clearance patient has tried and failed (check all that apply):

- CPT (manual or percussor) Oscillating PEP PEP Cannot use other methods Other

Check all reasons why therapy failed, or is contraindicated or inappropriate for this patient:

- Unable to tolerate therapy Aspiration risk Physical limitations of caregiver/lack of caregiver 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 1/1/09 confirms Bronchiectasis")

Please check box if patient nebulizer therapy is to be used in conjunction with HFCWO:

Clinic Information: Fac#
Item: High Frequency Chest Wall Oscillation (HFCWO) Device E0483
R
Phone: Fax:
1. Date of Signature (Required - MM/DD/YY)
2. Prescriber's Signature (Required - no stamped signatures accepted)
3. Print Prescriber's First and Last Name (Required)
4. NPI Number (Required)
Primary Diagnosis
Primary Diagnosis Code
Secondary Diagnosis
Secondary Diagnosis Code

PROTOCOL
Please Note: The Standard Protocol is used if any or all sections of the Custom Protocol are left blank.
Standard Custom
Treatments per Day 2
Minutes per Treatment 10-30
Frequencies 6-20
Minimum Minutes of Use per Day 10
Length of Need 99 months = Lifetime
Other Protocol Notes:
*Unless otherwise stated, settings titrated to accommodate patient efficacy and comfort.