Hillrom™

# PRESCRIPTION / ORDER FORM - The Volara™ System

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

Birth Date: ____ / ____ / ____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

Facility Contact Person: _____
Phone: _____
E-mail: _____
Following Physician/PCP: _____
Phone: _____
E-mail: _____

Patient Contact Name: _____ Relationship to Patient: _____

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

Date patient last seen: _____ 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) ☐ High Frequency Chest Wall Oscillation ☐ Mechanical Insufflation - Exsufflation
☐ Other Lung Therapies/Techniques

## Check all reasons why the above therapy failed or is contraindicated or inappropriate for this patient (Check all that apply):

☐ Physical limitations of caregiver ☐ Physical limitations of patient ☐ Artificial airway
☐ Inadequate time for complete therapies

## Relevant medical history in the past 12 months (Check all that apply):

☐ History of respiratory infections ☐ Atelectasis/lung collapse ☐ Mucus plugs
☐ Hospitalizations due to pulmonary exacerbations ☐ Inability to cough or clear secretions
☐ Decline in pulmonary function ☐ Other: _____

Comments:

**Clinic Information:** Fac#

_____
_____
_____
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)**

**Please include documentation of a Face to Face encounter with the patient for a medical condition that supports the need for the device. This is required before device shipment.**

℞ **The Volara™ System**
**(Oscillation and Lung Expansion & Supplies)**

_____ 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 | 10-20 (2.5 min/cycle) | |
| Oscillations | Medium-High | |
| CPEP | 5-25 $cmH_2O$ | |
| CHFO | 10-30 | |
| Length of Need | 99 | |

**Other Protocol Notes:**

**Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records**