Hillrom™

PRESCRIPTION / ORDER FORM The Synclara™ System

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

Birth Date: _____ Gender: _____ Primary Language: _____

_____
Street City State Zip

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

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: _____

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

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 provide proper documentation from the patient's medical record which supports any of the relevant medical history indicated below. (check all that apply):

- ☐ Impairment of the chest wall
- ☐ Diaphragm Impairment
- ☐ Inability to cough or clear secretions
- ☐ Diminished bulbar function
- ☐ Mucus Plugs
- ☐ Hx of Aspiration of saliva, food, liquid
- ☐ Frequent Respiratory Infections
- ☐ Decline in Pulmonary Functions
- ☐ Mechanical Ventilator
- ☐ ER visits due to Pulmonary Exacerbation
- ☐ Hospitalization due to Pulmonary Exacerbationon
- ☐ Tracheostomy
- ☐ Atelctasis

Please indicate methods of Airway Clearance patient has tried or currently using (check all that apply):

- ☐ CPT (manual or percussor)
- ☐ Flutter Device
- ☐ Cannot use other rmethods
- ☐ Nebulizeres/Inhalers
- ☐ High Frequency Chest Wall Oscillation
- ☐ Other: _____
- ☐ PEP

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.

Rx The Synclara™ System
(Mechanical Insufflation-Exsufflation)
Interface Supplies **Qty: 1 per month**
Battery Accessory **Qty: 1**

_____ 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	
Inhale/Exhale Pressure Range	+10/-10 to +50/-50	
PAP Pressure	+5	
Number of Cycles	15-20	
Length of Need	99	

Flutter ☐ Yes ☐ No
Sigh ☐ Yes ☐ No

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

Offered by Advanced Respiratory Inc., a Hillrom Company, 1020 West County Road F, St. Paul, MN 55126, Phone: 1.800.426.4224 www.respiratorycare.hill-rom.com