Hillrom™

# PRESCRIPTION / ORDER FORM - The Vest® Airway Clearance System

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

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

_____
Street City State Zip

Case Manager: _____
Phone: _____
E-mail: _____
Hospital Room#: _____
Discharge Date: _____

Primary Insurance & ID#: _____ Secondary Insurance & ID#: _____

Patient Contact Name: _____ Relationship to Patient: _____

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

Chest Measurement: _____ Garment Style: FULL VEST (Color: _____) / WRAP VEST / CHEST VEST

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)**

1. ☐ Y ☐ N Have alternative airway clearance techniques been tried and failed?

Please indicate methods of airway clearance patient has tried and failed (check all applicable boxes below):
☐ CPT (manual or percussor) ☐ Oscillating PEP ☐ PEP ☐ Other ☐ Cannot use other methods

Check all reasons why the above therapy failed or is contraindicated or inappropriate for this patient:
☐ No caregiver to provide therapy ☐ Feeding tubes ☐ Unable to form mouth seal ☐ Young age
☐ Physical limitations of caregiver ☐ Aspiration risk ☐ Insufficient expiratory force ☐ Did not mobilize secretions
☐ Gastroesophageal reflux (GERD) ☐ Kyphosis/scoliosis ☐ Artificial airway ☐ Severe arthritis, osteoporosis
☐ Resistance to therapy ☐ Cognitive level ☐ Spasticity/contractures ☐ Unable to tolerate positioning/percussion

2. ☐ Y ☐ N Has there been daily productive cough for at least 6 months?

3. Relevant medical history in past year (check all applicable boxes below):
☐ History of respiratory infections ☐ Hospitalizations due to pulmonary exacerbation ☐ Sputum cultured positive for resistant bacteria
☐ Atelectasis ☐ ER visits due to pulmonary exacerbation ☐ More than 2 exacerbations requiring antibiotic therapy in the last year:
☐ Mucus plugs ☐ Decline in pulmonary function ☐ IV antibiotics ☐ Oral antibiotics

4. For Bronchiectasis patient, please check Yes or No to the following question:
☐ Y ☐ N Has there been a CT scan confirming Bronchiectasis diagnosis? If Yes, please attach required report.

**Hospital Information:** Fac#

Address:

Phone: Fax:

1. _____
**Signature Date (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 Vest® Airway Clearance System**
E0483

_____
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 | 20 | |
| Frequencies | 6-15 | |
| Minimum Minutes of Use per Day | 10 | |
| Length of Need | 99 months = Lifetime | |

**Other Protocol Notes:**

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