

PRESCRIPTION / ORDER FORM
The Synclara™ 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#: _____

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):

- | | | |
|---|---|--|
| <input type="checkbox"/> Impairment of the chest wall | <input type="checkbox"/> Hx of Aspiration of saliva, food, liquid | <input type="checkbox"/> ER Visits due to Pulmonary Exacerbation |
| <input type="checkbox"/> Diaphragm Impairment | <input type="checkbox"/> Frequent Respiratory Infections | <input type="checkbox"/> Hospitalization due to Pulmonary Exacerbation |
| <input type="checkbox"/> Inability to cough or clear secretions | <input type="checkbox"/> Decline in Pulmonary Function | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Diminished bulbar function | <input type="checkbox"/> Mechanical Ventilator | <input type="checkbox"/> Atelectasis |
| | | <input type="checkbox"/> Mucus Plugs |

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

- | | | |
|--|--|------------------------------|
| <input type="checkbox"/> CPT (manual or percussor) | <input type="checkbox"/> Nebulizers/Inhalers | <input type="checkbox"/> PEP |
| <input type="checkbox"/> Flutter Device | <input type="checkbox"/> High Frequency Chest Wall Oscillation | |
| <input type="checkbox"/> Cannot use other methods | <input type="checkbox"/> Other: | |

Comments:

<p>Clinic Information: _____ Fac# _____</p> <p>_____</p> <p>_____</p> <p>Phone: _____ Fax: _____</p> <p>1. _____ Signature Date (Required - MM/DD/YY)</p> <p>2. _____ Prescriber's Signature (Required - no stamped signatures accepted)</p> <p>3. _____ Print Prescriber's First and Last Name (Required)</p> <p>4. _____ NPI Number (Required)</p> <p>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.</p>	<p align="center">Rx The Synclara™ System (Mechanical Insufflation- Exsufflation) Interface Supplies Qty: 1 per month Battery Accessory Qty: 1</p> <p>Primary Diagnosis _____</p> <p>Primary Diagnosis Code _____</p> <p>Secondary Diagnosis _____</p> <p>Secondary Diagnosis Code _____</p>	<p align="center">PROTOCOL</p> <p>Please Note: The Standard Protocol is used if any or all sections of the Custom Protocol are left blank.</p> <table border="0"> <thead> <tr> <th></th> <th align="center">Standard</th> <th align="center">Custom</th> </tr> </thead> <tbody> <tr> <td>Treatments per day</td> <td align="center">2</td> <td>_____</td> </tr> <tr> <td>Inhale/Exhale Pressure Range</td> <td align="center">+15/-15 to +40/-40</td> <td>_____</td> </tr> <tr> <td>Inhale/Exhale Pause Time</td> <td align="center">2.0 seconds</td> <td>_____</td> </tr> <tr> <td>PAP Pressure</td> <td align="center">+5</td> <td>_____</td> </tr> <tr> <td>Number of Cycles</td> <td align="center">15-20</td> <td>_____</td> </tr> <tr> <td>Length of Need</td> <td align="center">99/Lifetime</td> <td>_____</td> </tr> <tr> <td>Flutter</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>Sigh</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> </tr> </tbody> </table>		Standard	Custom	Treatments per day	2	_____	Inhale/Exhale Pressure Range	+15/-15 to +40/-40	_____	Inhale/Exhale Pause Time	2.0 seconds	_____	PAP Pressure	+5	_____	Number of Cycles	15-20	_____	Length of Need	99/Lifetime	_____	Flutter	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sigh	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records