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 Vest® Airway Clearance System High Frequency Chest Wall Oscillation (HFCWO) device	VISIVEST Airway Clearance System	☐ The VisiVest® Airway Clearance System HFCWO device with wireless connectivity to the VisiViewHealth Portal®

Chest Measurement:__________ Garment Style: C3 VEST (Color:__________) / WRAP VEST

MONARCH®

☐ Monarch® Airway Clearance System Including Battery

Mobile HFCWO device with wireless connectivity to the VisiView® Health Portal. Patient's torso measurement (mid-chest) must be between 22-50".

Mid-torso measurement: __________ Torso length: __________ **(Both required if under 15 years of age)**

Facility Contact: Phone: Email:

Patient Name: __________ Primary Language:__________

(Required - please print) First Middle Last

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#

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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)

Item: High Frequency Chest Wall Oscillation (HFCWO) Device 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	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.