Hill-Rom

PRESCRIPTION / ORDER FORM

Brand Name	Check One Box (Required)	Description
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 VisiView® Health Portal
MONARCH™	☐ Monarch™ Airway Clearance System Including Replacement Batteries	Mobile HFCWO device with wireless connectivity to the VisiView® Health Portal Patient's torso measurement (mid-chest) must be between 22-50"

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: _____

Vest® and VisiVest™ Chest Measurement: _____ inches. Garment Style: C3 VEST (Color: _____) / WRAP VEST / CHEST VEST

Monarch™ Torso measurement (mid-chest): _____ inches.

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)

Clinic Information:
Name:
Address:
City: State: Zip:
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.

Item: ℞

High Frequency Chest Wall Oscillation (HFCWO) Device

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

PRESCRIPTION / ORDER FORM
High Frequency Chest Wall Oscillation (HFCWO)

Patient Name: _____ Birth Date:___ / ___ / ___
(Required - please print) First Middle Last

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. 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. 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
☐ Atelectasis
☐ Decline in pulmonary function
☐ Mucus plugs
☐ Hospitalizations due to pulmonary exacerbation
☐ ER visits due to pulmonary exacerbation
☐ Sputum cultured positive for resistant bacteria
☐ More than 2 exacerbations requiring antibiotic therapy in the last year:
  ☐ IV antibiotics ☐ Oral antibiotics

4. For Bronchiectasis patient, please check Yes or No to the following question:

Has there been a CT scan confirming Bronchiectasis diagnosis? If Yes, please attach required report.

Prescribed by:

_____ _____ _____
Print First and Last Name (Required) **Signature (Required)** **Date (Required)**

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