

Cough Assist Order Form

| Company | Phone #: Fax #: | | |
|--|---|----------------------|--------------------------|
| PATIENT INFORMATION | | | |
| Patient Name: | Date Prescribed: | / | 1 |
| Date of Birth: / / | Length of Need: 99 mo | nths (lifetime) OR | # of months) |
| Home Phone/Cell #: | ICD-10 (Diagnosis): | | |
| Address: | <u></u> | | |
| City: State: Zip: | <u></u> | | |
| Email: | _ | | |
| COUGH ASSIST EQUIPMENT | | | |
| Cough Assist Therapy (Mechanical In-exsufflation) Device (E0482 | 2) | | |
| REPLACMENT SUPPLIES | | | |
| ☐ Interface for Cough Stimulating Device (A7020) includes mouthp | piece, mask, tracheostomy | | |
| Size (check box): | | | |
| ☐ Small ☐ Medium | Lar | rge | |
| SETTINGS The standard will be followed if any or all sections of the custom pr Treatments/day | otocol are blank. Settings m Standard 2 | nay be adjusted to p | catient comfort. Custom |
| Inhale/Exhale Pressure | (+/-) 5 - 70 cm h20 | | |
| Pause Pressure | 1 - 15 cm h20 | | |
| Inhale/exhale/pause time | 0 - 5 seconds | | |
| Comfort settings (inspiratory trigger, advanced settings, flow) | Adjust to patient comfort | t | |
| Oscillation settings (frequency and amplitude) | Adjust to patient comfort | t | |
| INCLUDE THIS DOCUMENTATION TO DISPENSE AND BILL: Documentation signed and dated by the physician to support • has a neuromuscular disease, AND • is clinical impairment, i.e., weakened chest wall or diaphra AND • any failed trials of standard airway clearance therapies (especially relevant when also using other airway clearance | e.g., chest physiotherapy, PE | | |
| Physician's Signature: | Date: | | |
| Physician's Printed Name: | NDI | | |
| Address: | City: | State: | Zip: |
| Phone: | Fax: | | |

Sales Rep Name:

