Airway Clearance Vest Therapy Fax Order Form

Medical Service Company

Sales Rep Name: _____
Phone #: _____
Fax #: _____

PATIENT INFORMATION

Patient Name: _____ **Date Prescribed:** ____/____/____

Date of Birth: ____/____/____ **Length of Need: 99 months (lifetime) OR** _____ **# of months)**

Home Phone/Cell #: _____ **Primary Diagnosis:** _____

Address: _____ **ICD-10 (Diagnosis):** _____

City: _____ **State:** _____ **Zip:** _____ Chest Circumference: _____

Email: _____ Abdomen Measurement: _____

AIRWAY CLEARANCE THERAPY **Tried and Failed. This must be documented in the patient's progress notes.**

1. Have alternative airway clearance techniques been tried and failed? ☐ Yes ☐ No

☐ CPT (manual or percussor) ☐ Hypertonic Saline ☐ Suctioning ☐ Mucomyst* (*Notes must document it prescribed for secretion mobilization)
☐ Huff Coughing ☐ Breathing Techniques ☐ Oscillating PEP (Flutter, Acapella®, Aerobika®, Pep Valve, Pep Mask)

2. Check all reasons why the above therapy failed, is contraindicated or inappropriate for this patient:

☐ Cannot tolerate positioning/hand CPT ☐ Cognitive level ☐ Severe arthritis, osteoporosis ☐ Insufficient expiratory force
☐ Physical limitations of caregiver ☐ Too fragile for hand CPT ☐ Unable to form mouth seal ☐ Resistance to therapy
☐ Caregiver unable to perform adequate CPT ☐ Gastroesophageal reflux (GERD) ☐ Did not mobilize secretions ☐ Artificial airway

3. For Cystic Fibrosis or Neuromuscular patients, the following must be documented in the patient's progress notes. **Attach records with RX.**

☐ Documentation supporting diagnosis ☐ Tried and failed a lesser airway clearance technique indicated above

4. For Bronchiectasis patients, the CT scan and diagnosis of bronchiectasis must be recorded in the radiologist's report.

Has there been a CT scan confirming Bronchiectasis diagnosis? ☐ Yes ☐ No **If "Yes" include copy of CT scan interpretation.**

In addition, the following medical history in the past year must be documented in the patient's progress notes. A**ttach records with RX.**

Frequent (i.e. more than 2/year) exacerbations requiring antibiotic therapy **OR**

Daily productive cough for at least 6 continuous months

RX: HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO); HCPCS E0483

Start Date: _____ Check need of Length: ☐ Lifetime (99) ☐ Other: _____

☐ Standard Prescription: Use the HFWCO at 5Hz–20Hz for 30 minute treatments twice per day (minimum of 15 minutes per day)

☐ Custom Prescription: Use the HFWCO at _____ Hz for _____ minute treatments _____ per day

☐ Please check box if nebulizer therapy to be used in conjunction with HFCWO

Physician's Signature: _____ **Date:** ____/____/____

Physician's Printed Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____