Hillrom™

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) with wireless connectivity to the Connex® App and Health 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 Connex® App and Health Portal.
Patient's mid-torso measurement must be between 22-50".

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

Facility Contact: Phone: Email:

Patient Name: (Required - please print) _____ Primary Language:_____
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: ☐

Check box if home spirometer use with the Connex App is recommended for the patient: ☐

Clinic Information: Fac#

_____

_____

_____

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 Rx

_____ 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: