Hillrom™

PRESCRIPTION / ORDER FORM

The Volara™ System

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: _____

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)

Please indicate methods of airway clearance patient has tried and failed (Check all that apply):

☐ CPT (manual or percussor) ☐ High Frequency Chest Wall Oscillation ☐ Mechanical Insufflation - Exsufflation
☐ Other Lung Therapies/Techniques

Check all reasons why the above therapy failed or is contraindicated or inappropriate for this patient (Check all that apply):

☐ Physical limitations of caregiver ☐ Physical limitations of patient ☐ Artificial airway
☐ Inadequate time for complete therapies

Relevant medical history in the past 12 months (Check all that apply):

☐ History of respiratory infections ☐ Atelectasis/lung collapse ☐ Mucus plugs
☐ Hospitalizations due to pulmonary exacerbations ☐ Inability to cough or clear secretions
☐ Decline in pulmonary function ☐ Other:

Comments:

Clinic Information: Fac#

_____

_____

_____

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)

Rx The Volara™ System
(Oscillation and Lung Expansion)
Interface Supplies Qty: 1 per month
Battery Accessory Qty: 1

_____
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	10-20 (2.5 min/cycle)	
Oscillations	Medium-High	
CPEP	5-25 cmH_2O	
CHFO	10-30	
Length of Need	99	

Other Protocol Notes:

Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records