The Vest APX System Prescription/Order Form

Offered by Advanced Respiratory Inc., a Baxter Company, 1020 West County Road F, St. Paul, MN 55126, Phone: 1.800.426.4224 www.baxter.com

REQUIRED ATTACHMENTS: patient demographics, copy of insurance card, medical records, and face to face encounter documents

Patient Name: _____
(Required - please print) First Middle Last

Birth Date: ____ / ____ / ____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Chest Circumference: _____
Height: _____
Weight: _____
Garment Type: ☐ Vest ☐ Wrap
Size/Color: _____

Primary Insurance & ID#: _____ Secondary Insurance & ID#: _____

Patient Contact Name: _____ Relationship to Patient: _____

Phone: _____ ☐ H ☐ C ☐ W Alt Phone: _____ ☐ H ☐ C ☐ W E-mail: _____

Following Physician/PCP: _____ Phone: _____ E -mail: _____

Facility Contact: _____ Phone: _____ 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 provide supporting documentation for all checked boxes.

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: ☐

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)

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.

Rx Item: High Frequency Chest Wall Oscillation (HFCWO) Device E0483

_____
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	See Below	
Minimum Minutes of Use per Day	10	
Length of Need	99 months = Lifetime	

Other Protocol Notes:

13,12,11,10,9,8 3min/hz
+6 full vest
+4 wrap vest
Titrate as appropriate for pt tolerance

Fax to 1.800.870.8452 with face sheet, copy of insurance card, and medical records

Revised 03/2024