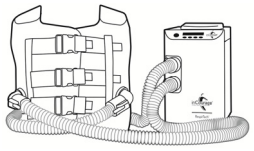
Vest Therapy Rx Order Checklist



Fax Cover Sheet			
To:	**RespirTech**	Facility Name:	
Fax:	**866.727.3235**	Sender Name:	
Date		Sender Phone:	
Re:	**Prescription for Vest Therapy**	Sender Email:	
		# of Pages:	

PLEASE INCLUDE THE FOLLOWING:

- ☐ Physician Signed and Dated Prescription
- ☐ Patient Demographic/Face Sheet
- ☐ Copy of Patient's Insurance Card(s) (if available)
- ☐ Signed Patient Consent Form (if available)
- ☐ Medical Records for the past 6 months
  - ☐ Include other airway clearance therapies tried and/or considered (e.g., Flutter®, Acapella®, CPT)
  - ☐ Include reason(s) other airway clearance therapies were inappropriate, contraindicated or failed
- ☐ *Also include* for BRONCHIECTASIS patients:
  - ☐ Chest CT Imaging report confirming diagnosis ***OR*** Statement in Medical Record
  - ☐ Documentation in medical record of daily productive cough for at least 6 continuous months ***OR*** 3 or more exacerbations within the past year requiring antibiotic therapy

QUESTIONS? Call RespirTech at 800.793.1261

COMMENTS: