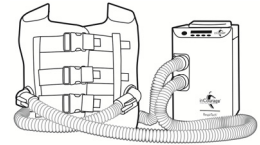


# Vest Therapy Rx Order Checklist



Fax Cover Sheet			
To:	<b>RespirTech</b>	Facility Name:	
Fax:	<b>866.727.3235</b>	Sender Name:	
Date		Sender Phone:	
Re:	<b>Prescription for Vest Therapy</b>	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:**

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