# Rx Order Check List / Fax Cover Sheet

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|---|---|---|---|
| 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 ITEMS *(if available)*

- ☐ ***Physician Signed and Dated Prescription*** with physician's NPI
- ☐ Patient Demographic/Face Sheet
- ☐ Copy of Patient's Insurance Card(s) (front and back)
- ☐ Medical Records for the past 12 months, including any referral letters and hospital discharge summaries

  ***PLEASE NOTE: The following items must be documented in the patient's medical record to support the prescription for vest therapy:***
  - Face-to-face encounter with the patient
    (Must be on or during the 6 months prior to the date of the vest therapy prescription)
  - Other standard treatments for airway secretion clearance have been tried and failed, or are inappropriate for the patient's condition

- ☐ **FOR BRONCHIECTASIS PATIENTS:**
  - Chest CT Scan report confirming diagnosis
  - Documentation in medical record of;
    A. Daily productive cough for at least 6 continuous months; **OR**
    B. Exacerbation requiring antibiotic therapy at least 3 times within the last year
- ☐ Signed Patient Consent Form if patient is available

**QUESTIONS? Call RespirTech at 800.793.1261**

**COMMENTS:**