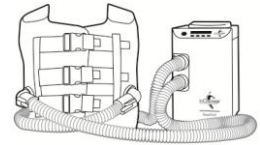


Vest Therapy Rx Order Checklist



Fax Cover Sheet			
To:	RespirTech	Facility Name:	
Fax:	800.962.1611	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:

Flutter® is a registered trademark of VarioRaw Percutive S. à.r.l., a subsidiary of Aptalis Pharma US, Inc. Acapella® is a registered trademark of Smiths Medical.

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