Cough Assist Order Form

Apria Representative _____ **Branch Location** _____ **Fax** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
LAST FIRST

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

Diagnosis ICD-10: Each diagnosis requires a corresponding ICD-10 code and must be corroborated in the patient's medical record. Please enter the appropriate qualifying diagnoses and corresponding ICD-10 codes. (Note: Ranges are not acceptable.)

- ☐ Amyotrophic lateral sclerosis (ALS) (G12.21)
- ☐ Muscular dystrophy, unspecified (G71.00))
- ☐ Myopathy, unspecified (G72.9)
- ☐ Polyneuropathy, unspecified (G62.9)
- ☐ Myasthenia gravis (G70.00 – G70.01)
- ☐ Other _____
- ☐ Spinal muscular atrophy, unspecified (G12.9)
- ☐ Other muscular dystrophies (G71.09)
- ☐ Guillain Barré syndrome (G61.0)
- ☐ Cerebral Palsy (G80.0 – G80.9)
- ☐ Myoneural disorder, unspecified, and other (G70.9)

EQUIPMENT ORDERED	
☐ **E0482 Mechanical In Exsufflation Device (Cough Assist)**	**Length of Need:** ☐ **99 months (lifetime)** ☐ **Other** _____
☐ **A7020 Patient Circuit and Interface** ☐ **Mask – fit to patient comfort** **OR Select Mask Size:** ☐ **Pediatric** ☐ **Adult Small** ☐ **Adult Medium** ☐ **Adult Large** ☐ **Mouthpiece** ☐ **Tracheostomy**	

Protocol: The standard protocol will be followed if any or all sections of the custom protocol are blank. Settings may be adjusted to patient comfort and/or with a peak cough flow goal >160 lpm. Auscultation of the upper airway may be performed to evaluate upper airway stability in patients with bulbar syndrome.

	STANDARD	CUSTOM
Treatments/Day	2	
Inhale/Exhale Pressure	(+/-) 5 = 70cm h_20	
Pause Pressure	1 - 15 cm h_20	
Inhale/exhale/pause time	0 - 5 seconds	
Comfort settings (inspiratory trigger, advanced settings, flow)	Adjust to patient comfort	
Oscillation settings (frequency and amplitude)	Adjust to patient comfort	

By signing below, I authorize the use of this document as a prescription. I understand that the final decision with respect to ordering this (these) items(s) for the patient is a clinical decision made by me, based on the patient's clinical needs and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____

©2026 Apria Healthcare Group LLC | RES-4762 6/26_v2