High Frequency Chest Wall Oscillation 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 _____

Length of need: ☐ Lifetime (99) ☐ Other

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes.

☐ Bronchiectasis _____ ☐ Diaphragmatic Paralysis _____ ☐ Disorders of the Diaphragm _____
☐ Cystic Fibrosis _____ ☐ Amyotrophic Lateral Sclerosis (ALS) _____ ☐ Multiple Sclerosis _____
☐ Muscular Dystrophy _____ ☐ Quadriplegia _____ ☐ Other _____

☐ Measurements: Chest circumference _____ Abdominal measurement _____ ☐ Provider to measure
(Measure fullest part of the chest at nipple line) (Measure largest circumference of abdomen at belly button line)

Airway Clearance Therapy Tried and Failed. This must be documented in the patient's record.

1. **Have alternative airway clearance techniques been tried and failed?** ☐ Yes ☐ No
   Please indicate methods of airway clearance patient has tried and failed (check all that apply)
   ☐ CPT (manual or percussor) ☐ Oscillating PEP (Flutter, Acapella, Aerobika, PEP Valve, PEP Mask) ☐ Huff Coughing ☐ Breathing Techniques
   ☐ Mucomyst (notes must document prescribed for secretion mobilization) ☐ Hypertonic Saline ☐ Suctioning
2. **Check all reasons why the above therapy failed, is contraindicated, or inappropriate for this patient:**
   ☐ Cannot tolerate positioning/hand CPT ☐ Too fragile for hand CPT ☐ Did not mobile secretions ☐ Physical limitations of caregiver
   ☐ Caregiver unable to perform adequate CPT ☐ Insufficient expiratory force ☐ Gastroesophageal reflux (GERD)
   ☐ Severe arthritis, osteoporosis ☐ Resistance to therapy ☐ Cognitive level – Unable to form mouth seal ☐ Artificial airway ☐ Other
3. **For Cystic Fibrosis or Neuromuscular patients, the following must be documented in the patient's record. Please attach records with Rx.**
   ☐ Documentation of supporting diagnosis ☐ Tried and failed lesser airway clearance technique indicated above
4. **For Bronchiectasis patients, please check Yes or No to the following questions:**
   Has there been a CT scan confirming Bronchiectasis diagnosis? ☐ Yes ☐ No (if "Yes" please include copy of CT scan interpretation)
   In addition, the following medical history in the past year must be documented in the patient notes. Please attach records with the RX.
   ☐ 3 or more exacerbations, i.e., lung infections, requiring antibiotics, documented 3 separate times; **OR**
   ☐ Daily productive cough for at least 6 months

High Frequency Chest Wall Oscillation (HFCWO HCPCS E0483)

☐ Dispense one High Frequency Chest Wall Oscillation System (E0483)
☐ Frequency of Use (standard): Use at 5Hz-20Hz for 30-minute treatments twice per day (minimum 15 minutes per day)
☐ Frequency of use (custom): use at _____ Hz for _____ minute treatments _____ per day
☐ Please check box if nebulizer therapy is to be used in conjunction with HFCWO

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** _____

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