MED SYSTEMS®

PRESCRIPTION/ORDER FORM DME E1399

ElectroFlo 5000 Airway Clearance System

Please fax to **858-483-9827**

Facility Information:

Contact Person: _____

Phone: _____

Email: _____

Physician/PCP:

Contact Person: _____

Phone: _____

Email: _____

Patient Name: _____
(Required - please print) First Middle Last

Birth Date: _____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

Patient Contact Name: _____ Relationship to Patient: _____

Phone: _____ ☐ H ☐ C ☐ W Phone: _____ ☐ H ☐ C ☐ W

E-mail: _____

BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

Prescriber must initial and date any revisions made after the prescriber has signed order form

Date patient last seen: _____ Is the patient currently in the hospital? Discharge Date: _____

1. ☐ Yes ☐ No Have alternative airway clearance techniques been tried and failed?

Check all methods of airway clearance patient has tried and failed below:

☐ CPT - manual ☐ Oscillating PEP ☐ PEP ☐ Other ☐ Cannot use other methods ☐ Vest device

Check reasons why the above therapy failed or is contraindicated or inappropriate for this patient:

☐ Physical limitations of caregiver	☐ Feeding tube(s)	☐ Unable to form mouth seal
☐ Severe arthritis, osteoporosis	☐ Gastroesophageal reflux (GERD)	☐ Aspiration risk
☐ Insufficient expiratory force	☐ Did not mobilize secretions	☐ Spasticity/contractures
☐ Kyphosis/scoliosis	☐ Artificial Airway	☐ Young Age
☐ Resistance to therapy	☐ Cognitive level	☐ Port(s)

2. ☐ Yes ☐ No Has there been daily productive cough for at least 6 months?

3. Past year relevant medical history in past year (circle all that apply below):

☐ History of respiratory infections	☐ Hospitalizations due to pulmonary exacerbation
☐ Sputum cultured positive for resistant bacteria	☐ Atelectasis
☐ ER visits due to pulmonary exacerbation	☐ Did not mobilize secretions

☐ More than 2 exacerbations requiring antibiotic therapy in the last year:

☐ Mucus plugs ☐ Decline in pulmonary function ☐ IV antibiotics ☐ Oral antibiotics

4. Bronchiectasis patients, please check Yes or No to the following question:

☐ Yes ☐ No Has there been a CT scan confirming Bronchiectasis diagnosis? If Yes, please attach required report

Clinic Information FAC# _____

_____ _____
Phone: Fax:

1. _____
Signature Date (Required - MM/DD/YY)

2. _____
Prescriber's Signature (required - no stamped signatures)

3. _____
Printed Prescriber's First and Last Name (Required)

4. _____
NPI Number (required)

℞ ☐ **ElectroFlo 5000 Airway Clearance System**

NO SUBSTITUTIONS

☐ **BRAND MEDICALLY NECESSARY**

Primary Diagnosis _____

Primary Diagnosis Code _____

Secondary Diagnosis _____

Secondary Diagnosis Code _____

Please include documentation of a Face to Face patient encounter for a medical condition that supports the need for the device. This is required before device shipment of ElectroFlo 5000 Airway Clearance System.

PROTOCOL

Note: The Standard Protocol is used if any or all sections of the Custom Protocol are left blank.

	Standard	Custom
Treatments per Day	2	
Minutes per Treatment	20	
Minimum Minutes of use per tx	10	

Other Protocol Notes: