HANDI MEDICAL SUPPLY

Standard Written Order: AffloVest

Prescriber Information

Phone:
Fax:
NPI:

Patient Information

Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10)

HCPCS	Description	Dispensing Qty	Frequency of Change

1. Ordered Date: ______________________

2. Length of Need: ______________________
Leaving blank presumes Lifetime (99 months)

3. Chest Circumference: ______________________
(Measure fullest part of chest at nipple line)

4. Abdomen Measurement: ______________________
(Measure largest circumference of abdomen at belly button line)

5. Complete the following use/setting information:

- ☐ Frequency of Use (standard): Use the AfloVest at 5Hz–20Hz for 30 minute treatments twice per day (minimum of 15 minutes per day)
- ☐ Frequency of Use (custom): Use the AffloVest at __________ Hz for ___________ minutes treatments ___________ per day
- ☐ Please check box if nebulizer therapy to be used in conjunction with HFCWO

6. 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 Hypertonic
- ☐ Breathing Techniques
- ☐ Mucomyst* (*Notes must document it prescribed for secretion mobilization)
- ☐ Saline
- ☐ Suctioning

7. Check all reasons why the above therapy failed, is contraindicated or inappropriate for this patient

- ☐ Cannot tolerate positioning/hand
- ☐ Too fragile for hand CPT
- ☐ Did not mobilize secretions
- ☐ CPT Physical limitations of caregiver
- ☐ Unable to form mouth seal
- ☐ Insufficient expiratory force
- ☐ Gastroesophageal reflux (GERD)
- ☐ Severe arthritis, osteoporosis
- ☐ Resistance to therapy
- ☐ Cognitive level
- ☐ Caregiver unable to perform adequate CPT
- ☐ Artificial airway
- ☐ Other:

8. Please attach medical records supporting necessity of the above ordered item(s).

9. ____ ____________________
Physician/NP/PA/Medical Practitioner Signature — Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: ______________________ NPI: ______________

Fax back: **651-644-0602**

www.handimedical.com

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