Integrated Respiratory Solutions

Prescription/ Written Order Prior to Delivery
Phone: 630.582.0202 - Fax: 630.582.3787

Patient Information

Patient First Name | Patient Last Name | Gender | Date of Birth

Patient Phone Number | Patient Primary Insurance | Policy Number | Height/ Weight

Narrative Diagnosis Descriptions & ICD-10 Codes

Patient Chest Circumference (nipple line) & Abdomen Circumference (navel line)

Prescription/ Written Order Prior to Delivery

Start Date:_____ Length of Need: ☐ 99 (Lifetime) ☐ Other: _____

☐ Dispense one AffloVest by International Biophysics Corporation/ High Frequency Chest Wall Oscillation System/ E0483

☐ Frequency of Use (standard): Use the AffloVest at 5Hz- 20Hz for 30 minute treatments twice per day (minimum of 10 minutes per day)

☐ Frequency of Use (Custom): Use the AffloVest at _____ Hz for _____ minute - treatments _____ per day

Physician Signature (stamped signature not accepted) | Date:

Physician Printed Name | NPI Number

Physician Address | City | State | Zip

Physician Phone | Physician Fax

Alternate Contact Name | Phone | Email

I certify the accuracy of this Rx for the AffloVest Airway Clearance System and that I am the physician identified in this form. I certify that the medical information provided above and in the supplementary documentation is true, accurate, and completed to the best of my knowledge. The patient record contains the supplementary documentation to substantiate the medical necessity of the AffloVest and physician notes will be provided to the authorized AffloVest distributor by request. By providing this form to an authorized AffloVest distributor, I acknowledge that the patient is aware that he or she may be contacted by said distributor for any additional information to process this order.