Beneficiary / Patient Name: ______________________ **DOB:** ______________

Phone:______________ **Mobile:** ______________ **Order Date:** ______________

High Frequency Chest Wall Oscillation Device (HFCWO) (HCPCS: E0483)

Check Length of Need *(Only check one option):* ☐ **Lifetime (99)** ☐ Other______________
(If selected, must indicate # of months)

Diagnoses: ______________ , __________ , __________ , __________ , __________
(List all primary, secondary and underlying pulmonary, neurologic and other myopathy diagnoses that apply.)

Quick Start Protocol

☐ Tx/Day: 2 | Minutes/Tx: 30 | Frequencies: 6-15Hz | Pressure: 60-100% (or as tolerated by patient) | Minimum usage/day: 10 minutes

Custom Protocol:

☐ Tx/Day: _____ | Minutes/Tx: _____ | Frequencies: __________ | Pressure: ____________ (or as tolerated by patient)

Patient Vest Measurements:

Measurements *(All Four Measurements Required).*	**Exact Inches**	
❶ Largest circumference around chest/bust		
❷ Largest circumference around abdomen while positioned for therapy		
❸ Top of shoulder to top of hip bone	R	L
❹ Armpit to top of hip bone	R	L

Vest Color Preference

☐ Pixel Puzzle ☐ Northern Lights ☐ Passion Pink Camo
☐ Flower Power ☐ Star Galaxy ☐ Wild Camo
☐ Black ☐ Pink ☐ Blue

Patient Info:

______ Height (inches) ______ Weight (lbs.)

☐ Patient has Trach ☐ Patient has Port/Line

Note any Special needs or Patient concerns:

Printed Physician Name: ______________________ **NPI:** ______________________

Physician Signature:______________________________ **Date:** ______________

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