

Vibralung® Acoustical Percussor Prescription Form Phone: 800-889-5231 Fax: 303-805-9629

Clinic Name: _____ Contact Person: _____ Phone: _____
 Address: _____ City/State: _____ Zip: _____

Patient Name: _____ DOB: _____
 Address: _____ City/State: _____ Zip: _____
 Phone (Home): _____ (Cell): _____ Email: _____
 Primary Care Physician: _____ Phone: _____
 Diagnosis: _____ Diagnosis Code: _____ Length of need (99 = Lifetime) _____
 Secondary DX: _____ Secondary DX Code: _____

1. Patient has tried the following and continues to have difficulty mobilizing secretions:

___ CPT ___ Flutter ___ Acapella ___ Aerobika ___ AirPhysio Other _____

2. Reasons for Failure: ___ No caregiver/Physical limitations of caregiver

___ GERD ___ Unable to tolerate positions for CPT ___ Insufficient Exp Force

___ Poor Secretion Mobilization ___ Resistance to therapy Other _____

3. Has there been a productive cough for the last 6 months? ___ Yes ___ No

4. History: ___ Repeated Respiratory Infections ___ Atelectasis ___ Mucus Plugs ___ IV/Oral Antibiotics

___ ER Visits for Pulmonary Exacerbations ___ Decline in Pulmonary Functions

Other _____

___ E1399 – PN 9501 Vibralung Acoustical Percussor Complete Kit
 ___ E1399 – PN 9600 Handheld Transducer with Patient Change Kit _____ Refill PRN
 ___ E1399 – Disposable Change Kit: Qty ___2 ___5 ___10 Other _____ Refill PRN (PN 9640 25 pack)
 ___ A7003 – PN 0393R Circulaire II Nebulizer (Disposables only) _____ Refill disposables PRN

Treatment Usage Directions (manufacturer recommendations)

The Vibralung's tonal settings (L-Low, M-Medium, and H-High – 10 min each) mobilize mucus for airway clearance, and the random noise settings (R2 and R5 – 2 or 5 mins) relax and open the airways. Reduction in mucus production is the measure of when to move to a higher mode. If wheezing, do R2 before L, M, or H. Start with PEP valve half open, adjust as needed.

General Time Frame in weeks	1 - 3 weeks	1 - 3 weeks	1 - 3 weeks
<input type="checkbox"/> COPD/CF/ Other chronic conditions	L + R2 or R5	L or M + R2 or R5	M or H t+ R2 or R5
<input type="checkbox"/> Asthma, wet	L + R2 or R5	L or M + R2 or R5	M or H + R2 or R5
<input type="checkbox"/> Asthma, dry	R5 + R5 + R5	R5 + R5	Continue as needed
General Time Frame in days	1 day	2-4 days	Continue as needed
<input type="checkbox"/> Pneumonia	R2 + L or M + R5	R2 + M or H + R5	R2 + M or H + R5

_____ Take 2 or 3 treatments per day, and up to 5 per day if have an exacerbation.

_____ Other: _____

Neuromuscular - Recommended Usage

Morning L-Low, followed by R2 or R5.
Afternoon M-Medium, followed by R2 or R5.
Evening L-Low, followed by R2 or R5.

After the first week, every third or fourth day change to these directions.

Morning M-Medium, followed by R2 or R5.
Afternoon H-High, followed by R2 or R5.
Evening M-Medium, followed by R2 or R5.

As needed, follow each treatment with postural drainage.

Other Conditions or Other Directions

By my signature, I am prescribing the items listed above for my patient. In my judgment, the above prescribed item(s) are medically indicated and necessary in regards to this patient's diagnosis.

Physician's Signature

Date

Physician's Name (Printed)

NPI #

Fax Instructions

If patient has private or commercial insurance: Please fax form along with Copy of Insurance Card(s), Clinical Notes/Medical Records for one visit supporting diagnosis, and Letter of Medical Necessity.

Medicare/Medicaid assignment is not accepted at this time. Income based pricing, no-interest payment plan, and patient assistance (low income) program available.