HAYEK MEDICAL
A UNITED HAYEK COMPANY

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HOME CARE ORDER CHECKLIST

PLEASE INCLUDE THE FOLLOWING ITEMS TO INITIATE A HOME CARE ORDER FOR BIPHASIC CUIRASS VENTILATION (BCV)

DOCUMENTATION AND INSURANCE INFORMATION

REQUIRED

- ☐ *MEDICAL RECORDS AND CHART NOTES, INCLUDING DIAGNOSES*
  - ☐ *Documentation of Biphasic Cuirass Ventilation order in chart notes, and why.*
  - ☐ *Documentation of failed PAP (if applicable)*
  - ☐ *Documentation of recent testing, and other clinical support*
- ☐ *PATIENT DEMOGRAPHICS*
- ☐ *INSURANCE INFO*
- ☐ *FAMILY DYNAMICS/SPECIAL NEEDS*
- ☐ *NURSING SERVICE*
- ☐ *PRESCRIPTION FOR BCV*
- ☐ *LETTER OF MEDICAL NECESSITY*

PRESCRIPTION FORM FOR BIPHASIC CUIRASS VENTILATION

REQUIRED

- ☐ *QUALIFYING DIAGNOSIS*
- ☐ *MODALITY AND PARAMETERS*
- ☐ *VENTILATORY SUPPORT*
- ☐ *LENGTH OF NEED*
- ☐ *SUPPLIES, SETTING CHANGES, AND ADJUSTMENT OF SETTING*
- ☐ *ALL REFERRING / ORDERING PHYSICIAN INFORMATION*
- ☐ *PHYSICIAN SIGNATURE*

OPTIONAL

- ☐ *SECRETION CLEARANCE*
- ☐ *VIBRATION MODE*
- ☐ *COUGH MODE*

Once the above items are received, the patient's information will be directed to one of the preferred home care providers (DMEs), based on the patient's area.

Upon final insurance authorization and approval, the home care provider can set-up the patient with BCV in the home.

FOR MORE INFORMATION ON YOUR LETTER OF MEDICAL NECESSITY, SEE BACK SIDE OF SHEET

Physician Prescription Form

1-855-243-8228

1-877-895-5583

Date: _____

Patient Information

Full Name: _____
Last *First* *M.I.*

Date of Birth: _____ Gender: ☐ Male ☐ Female

★ **Patient Height (Inches)** _____ ★ **Patient Weight (Lbs)** _____

☐ Biphasic Cuirass Ventilation – Continuous Negative Mode (CNEP)

Inspiratory Pressure:(-)_____**cmH_2O**

☐ 24 Hours Daily ☐ Nocturnally from_____pm to_____am ☐ Other:_____

☐ Biphasic Cuirass Ventilation – Control Mode

Frequency (rate):_____**cpm** **Inspiratory Pressure:(-)**_____**cmH_2O** **Expiratory Pressure:(+)**_____**cmH_2O** **I/E Ratio:**_____**:**_____

☐ 24 Hours Daily ☐ Nocturnally from_____pm to_____am ☐ Other:_____

☐ Biphasic Cuirass Ventilation – Respiratory Synchronized Mode

Back Up (rate):_____**cpm** **Inspiratory Pressure:(-)**_____**cmH_2O** **Expiratory Pressure:(+)**_____**cmH_2O**

Trigger Source: ☐ **Airway** ☐ **Cuirass** ☐ **Either Airway or Cuirass – titrate for comfort.**

☐ 24 Hours Daily ☐ Nocturnally from_____pm to_____am ☐ Other:_____

☐ Secretion Clearance Mode

Vibration Mode: **Frequency (vibration):**_____**cpm** **Inspiratory Pressure: (-)**_____**cmH_2O** **Time:**_____**minutes**

Cough Mode: **Frequency (cough):**_____**cpm** **Inspiratory Pressure: (-)**_____**cmH_2O** **Expiratory Pressure: (+)**_____**cmH_2O**

I/E Ratio:_____**:** _____ **Time:**_____**minutes** **Repeat Count:**_____

☐ 2 times daily ☐ 3 times daily ☐ 4 times daily ☐ Other:_____

Estimated Length of Need (# of Months) ☐ **99 = Lifetime** ☐ **Other Length of Need:** _____ **(Months)**

☐ **All required supplies for Biphasic Cuirass Ventilation (cuirass shell, cuirass seals, tubing, and straps)**

☐ **Adjust settings to patient comfort/compliance** ☐ **Notify physician of changes**

Notes:

Diagnosis: ☐ **Respiratory Failure** ☐ **ALS** ☐ **SMA** ☐ **COPD** ☐ **MD** ☐ **Chronic Asthma** ☐ **Chronic Bronchitis**
☐ **Cystic Fibrosis** ☐ **Bronchiectasis** ☐ **Post-Fontan** ☐ **Reoccuring Atelectasis** ☐ **CCHS** ☐ **Post Polio**
☐ **Bridge to Lung Transplant** ☐ **Restictive Lung Disease** ☐ **Other:** _____

Referring Physician: _____ Address: _____

Phone: _____ Fax: _____ License #: _____ NPI#: _____

I certify that I am the physician identified on this form. This form has been reviewed and signed by me. I certify that the prescribed services on this form are medically necessary. All information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____