Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

Application For Chest Wall Oscillator

IDENTIFICATION

CLIENT NAME	DATE OF BIRTH	PROVIDERONE CLIENT ID
NAME OF PRESCRIBING PHYSICIAN	TELEPHONE NUMBER	PROVIDER NPI

ICD 9 Dx	Description
ICD 9 Dx	Description

Medical Information (to be supplied by prescriber's office or independent respiratory therapist)

1. Is the client receiving CPT therapy? ☐ Yes ☐ No

2. Who performs the CPT? Can family members do CPT for the client? Do they need training? Does the client have private duty nursing to do CPT for the client?

3. Is the client able to use the "flutter", "pep", Acapella, or In-exsufflator? If not, why not? For how long have they tried to learn to use these techniques?

4. Clarity why all alternate methods of pulmonary toilet have failed including extenuating circumstances that have contributed to their failure:

5. For client's who are **currently using** the vest we need the following information:

Date the chest oscillator was started at home _____

Settings of oscillator _____

Daily prescription including frequency and duration _____

NUMBER OF HOSPITALIZATIONS FOR THE 12 MONTHS BEFORE VEST	NUMBER OF HOSPITALIZATIONS FOR THE 12 MONTHS AFTER VEST
TOTAL OFFICE VISITS FOR 12 MONTHS BEFORE VEST	TOTAL OFFICE VISITS FOR 12 MONTHS AFTER VEST
TOTAL ER VISITS FOR 12 MONTHS BEFORE VEST	TOTAL ER VISITS FOR 12 MONTHS BEFORE VEST

Number of episodes of outpatient antibiotic use 12 months before vest _____

Number of episodes of outpatient antibiotic use 12 months after vest _____

Best pulmonary function tests within 12 months before and after vest. (Attach).

6. If the client is **not currently using** the vest we will need the following information:

   Progress notes and Hospital discharge summaries for the last 12 months (Attach).

   Number of hospitalizations in the last 12 months _____

   Number of office visits in the last 12 months _____

   Number of ER visits in the last 12 months _____

   Number of episodes of outpatient antibiotic use in the last 12 months _____

   Best pulmonary function tests done in the last 12 months (Attach)

7. Copy of the prescription from the prescribing pulmonologist (Attach).

NAME OF PERSON COMPLETING THIS FORM	POSITION	BILLING PROVIDER NPI
TELEPHONE NUMBER	FAX NUMBER	

Please mail/fax to:

Medical Request Coordinator
Health and Recovery Services Administration
PO Box 45535
Olympia WA 98504-5535
Telephone 1-800-562-3022
FAX: 1-866-668-1214

A typed and completed General Authorization for Information form, DSHS 13-835, must be attached to your request in order to be processed by the Department.