Mechanical insufflation-exsufflation (MI-E) assessment/prescription form

RespirTech®

Fax to 800.962.1611 Questions? Call 800.793.1261

REQUIRED ATTACHMENTS: Patient demographic sheet | Copy of insurance card | Medical records

Patient information

Order date ____________________

Name (last) [ ] (First) [ ] M [ ] F [ ]

Date of birth____________________ Phone____________________ Medical record #____________________

Healthcare facility ____________ Phone ____________ Fax ____________ Anticipated discharge date, if currently hospitalized ____________

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Medical necessity assessment: This information must be supported in the patient's medical record and a copy of the record must accompany this prescription.

℞: MI-E device (HCPCS: E0482)

Quantity: 1 Unless otherwise noted:____________________

Interface for cough stimulating device (HCPCS: A7020)

Quantity: 1 per month Unless otherwise noted:____________________

☐ Mouthpiece ☐ Tracheostomy ☐ Mask

Check length of need
(Only check one option):

☐ **Lifetime (99)**

☐ **Other:**____________________

Protocol: The standard protocol will be followed unless the custom settings section is completed. Settings may be adjusted to patient comfort and/or with a peak cough flow goal >160 lpm. Auscultation of the upper airway may be performed to evaluate upper airway stability in patients with bulbar syndrome.

	Standard	Custom settings
Treatments and breathing exercises per day:	2 - 4	
Coughs per treatment:	4 - 10	
Long slow deep breathing exercises:	2 - 10	
Inhale and exhale pressure range:	(+/-) 5 - 70 cmH_2O	
Modes (manual, auto, advanced auto):	Adjust to patient comfort	
Inhale / exhale / pause times:	0 - 5 sec	
Comfort settings: *(Cough-trak, flow and pretherapy breaths)*	Adjust to patient comfort	
Oscillation settings: *(Frequency and amplitude)*	Adjust to patient comfort	

Diagnoses: *(List all primary, secondary and underlying neuromuscular, spinal cord injury and other diagnoses that apply.)*

1. [ ] (Code) [ ] 3. [ ] (Code) [ ]

2. [ ] (Code) [ ] 4. [ ] (Code) [ ]

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for MI-E from RespirTech, which, according to my professional judgment, is medically necessary for the patient identified above. The patient's record contains documentation supporting use of MI-E. I agree to provide such documentation to RespirTech and/or its authorized agents upon request. A copy of this order will be retained as part of the patient's medical record.

Practitioner signature [ ] Date [ ]

(Original signature and date required. Stamped signature and date not accepted.)

☐ Check box if you would like a 30-day evaluation

Practitioner name (print) [ ] NPI *(required)* [ ]

RespirTech personnel may fill in practitioner name and NPI prior to practitioner signature and date.

Respiratory Technologies, Inc. d.b.a. RespirTech
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