VOCSN

Physician Prescription for Respiratory Therapy with VOCSN

Patient Information

Name:	Phone:	DOB:
Primary Insurance:	Secondary Insurance:	

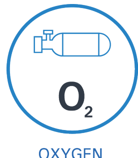
Ventilator ☐ *Check to prescribe*

☐ Non-Invasive Ventilation Mask: ☐ Invasive Ventilation

AC:	CV:	SIMV-Volume:	A/C+PRVC:
CPAP:	PC:	PC-SIMV:	S:
S/T:	T:	SIMV+PRVC:	

Estimated Length of Need (# of months): 1-99 (99=Lifetime)

Additional Notes:



Oxygen ☐ *Check to prescribe*

6 LPM Internal Concentrator (1-6 L/min): *(1-10 L/min can be bled in externally)*

Estimated Length of Need (# of months): 1-99 (99=Lifetime)

Additional Notes:

Cough ☐ *Check to prescribe*

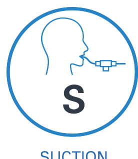
Pressure: Insufflation (10 to 70 cmH2O): Exsufflation (-10 to -70 cmH2O):

Time: Insufflation (0.0 to 5.0 seconds): Exsufflation (0.0 to 5.0 seconds):

Pause Time (0.0 to 5.0 seconds): Cycles:

Estimated Length of Need (# of months): 1-99 (99=Lifetime)

Additional Notes:



Suction ☐ *Check to prescribe*

Estimated Length of Need (# of months): 1-99 (99=Lifetime)

Additional Notes:

Nebulizer ☐ *Check to prescribe*

Medication: Frequency:

Estimated Length of Need (# of months): 1-99 (99=Lifetime)

Additional Notes:

Physician Information & Signature

Name:	Phone:	Fax:	NPI:
Signature:			Date:

Please attach patient demographics, copy of insurance card & additional documentation as required.

CAUTION: Please refer to the VOCSN Clinical and Technical Manual for detailed instructions, including indications and contraindications for use. Once it has been determined that VOCSN is clinically appropriate, please use this prescription template as a guide.