BiWaze® Cough SYSTEM

The Medical Equipment & Consumables Centre

Prescription Form

Patient Information							
Order Date							
Last Name		First Name				M ☐ F ☐	
Medical Record #		Phone			Date of Birth		
Street		City		State		Zip	
NDIS Number			DVA Number				
Contact Name			Primary Language				
Alt Phone			Email				
Healthcare Facility			Phone				
Fax			Anticipated Discharge Date				

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)

℞

Type	Description	Qty	Length of Time
MIE Therapy Device	BiWaze™ Cough System Please circle - Supply / Hire		☐ Lifetime (99) ☐ Other: _____
Patient Circuit Interface	☐ Mouthpiece ☐ Tracheostomy ☐ Mask Size: Pediatric - Adult Small - Adult Medium - Adult Large. Type: Inflatable / Anesthetic		☐ Monthly: _____ ☐ Other: _____

Protocol: The standard protocol will be followed if any or all sections of the custom protocol are blank. 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
Treatments/day	2	
Inhale/Exhale Pressure	(+/-) 5 – 70cm h_20	
Pause Pressure	1 - 15 cm h_20	
Inhale/exhale/pause time	0 – 5 seconds	
Comfort settings (Inspiratory trigger, advanced settings, flow)	Adjust to patient comfort	
Oscillation settings (frequency and amplitude)	Adjust to patient comfort	

Diagnosis: List all primary, secondary, and underlying diagnosis that apply

Diagnosis		Diagnosis	
1.		3.	
2.		4.	

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for the BiWaze™ Airway Clearance System and the patient circuit interface, which according to my professional judgement, is medically necessary for the patient identified above. The patient's record contains documentation supporting the use of MI-E therapy and I agree to provide such documentation upon request. A copy of this order will be retained as part of the patient's medical record.

Prescriber's Signature: _____ Date: _____

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

Prescriber's Printed Name: _____ MPN/HPI: _____

For more information or clarification on referring patients to the Medical Equipment Centre please contact your dedicated local Representative or call 1300 632 633.