State of Illinois
Department of Healthcare and Family Services

Questionnaire for Continued Rental of Airway Clearance Device

Patient Name: ______________________ DOB: ________________ RIN: __________________

1. Has the patient been hospitalized for a respiratory condition since use of the airway clearance device was started? Yes ☐ No ☐

   If yes, provide copies of all discharge summaries.

2. Has the patient required any antibiotics for respiratory exacerbations since the airway clearance device was started? Yes ☐ No ☐

   If yes, how many times? ____

3. Has the number of emergency room, urgent care, and office visits related to exacerbation of the respiratory conditions decreased since starting the airway clearance device? Yes ☐ No ☐ No change ☐

4. Do the patient and caregivers feel the patient's respiratory secretions are more easily expelled with use of the airway clearance device? Yes ☐ No ☐ No change ☐

5. Has the patient's respiratory status improved since using the airway clearance device? Yes ☐ No ☐ No change ☐

6. Has use of the therapy vest increased adherence to airway clearance therapy? Yes ☐ No ☐ No change ☐

____ ____________________

Practitioner's Signature with degree: Date

Office Phone #: __________________ Fax: ________________________ NPI: ________________