



# Medical Order

Automatic external defibrillator,  
with integrated electrocardiogram analysis, garment type

1-800-543-3267 (customer support)  
1-866-567-7615 (fax)

## Section A: Patient and insurance information

Patient name			Primary insurance		Phone number ( )	
Address			Group no.		ID/HICN	
City			Secondary insurance		Phone number ( )	
County		State	Group no.		ID/HICN	
Date of birth		Patient's phone number ( )				
Other insurance						

## Section B: Conditions and prescribing details Select or enter ICD-9 code(s) ↓

1 <input type="checkbox"/> Cardiac arrest due to VF or sustained VT (spontaneous or induced), not associated with an MI (>48 hours after MI). Check one: <input type="checkbox"/> VF <input type="checkbox"/> VT	<input type="checkbox"/> 427.41 <input type="checkbox"/> 427.42 <input type="checkbox"/> 427.1 <input type="checkbox"/> _____
2 <input type="checkbox"/> Familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmia, such as long QT syndrome or hypertrophic cardiomyopathy.	<input type="checkbox"/> 425.1 <input type="checkbox"/> 426.82 <input type="checkbox"/> 426.89 <input type="checkbox"/> _____
3 <input type="checkbox"/> MI or dilated cardiomyopathy with an ejection fraction of $\leq 35\%$ . Check conditions that apply: <input type="checkbox"/> Recent (<40 days) MI <input type="checkbox"/> Class IV NYHA CHF <input type="checkbox"/> Dilated Cardiomyopathy <input type="checkbox"/> Recent (<90 days) or planned CABG or PTCA <input type="checkbox"/> Other terminal illness	ICD-9 codes:
4 <input type="checkbox"/> Previously implanted defibrillator now requires explantation (explain):	<input type="checkbox"/> 996.61 <input type="checkbox"/> 996.04 <input type="checkbox"/> _____
5 <input type="checkbox"/> Condition with high risk of life-threatening VT/VF <u>not specified above</u> . Check one of the following: <input type="checkbox"/> VF or sustained VT with transient or reversible cause <input type="checkbox"/> Proarrhythmic drug use <input type="checkbox"/> MI, EF $\geq 36\%$ , with other risk factors <input type="checkbox"/> Prior to EP evaluation (syncope, NSVT, etc.) <input type="checkbox"/> Inotrope drug use <input type="checkbox"/> Other (describe):	ICD-9 codes:

### Other prescribing details

➔ Est. Length of need (check one):  6 months  5 months  4 months  3 months  2 months  Other: \_\_\_\_\_

VT heart rate threshold (BPM)	VF heart rate threshold (BPM)	Energy (joules)	Chest measurement (inches)	Weight <input type="checkbox"/> lbs <input type="checkbox"/> Kg
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## Section C: Description and medical justification

LifeVest Wearable Defibrillator System

Reasoning: Patient is at serious risk of sudden cardiac arrest resulting in death, neurological impairment, or other significant morbidity. WEAR DEVICE CONTINUALLY, with exception of bathing, to monitor heart rhythms and independently administer a shock if a tachyarrhythmia is detected.

## Section D: Prescribing physician and contact information

Physician's name		Physician's practice address		
State license number		City	State	Zip
NPI		Physician's phone number ( )		Physician's fax number ( )
Hospital where patient is being treated		Room No.		
Contact name			Contact phone number ( )	
Case manager (in hospital)			Case manager phone number ( )	
Scheduled discharge date (if hospitalized)		Discharge to (check one): <input type="checkbox"/> Home <input type="checkbox"/> Skilled nursing facil/Rehab		
Physician's signature X		Order date X		

## Medical Order

### Instructions:

**Complete Section A** – patient demographics (name, address, phone number, insurance information).

**Complete Section B** – diagnosis (reason patient needs the LifeVest). Also complete the Length of Need that the patient will need the LifeVest, along with the VT/VF and energy settings.

**Complete Section D** – Prescriber information. Prescriber must sign and date the order.

Fax the Medical Order form, hospital face sheet (if available), and clinical documentation (examples noted below) that support the patient’s diagnosis to ZOLL Lifecor: 1-866-567-7615.

### **Supporting documentation for patient conditions**

The following documentation should support patient conditions from Section B on page 1.

Condition	What to document	How to document
1 cardiac arrest due to VF or sustained VT	VF or sustained VT episode	Attach <b>one</b> of the following that identifies and dates the event: <ul style="list-style-type: none"> <li>• H&amp;P, progress note, consult note, or discharge summary</li> <li>• ECG/rhythm strip showing VF or sustained VT</li> <li>• EP study with induced VF or sustained VT</li> </ul>
2 familial or inherited SCA risk	evidence of syndrome leading to higher SCA risk	Attach <b>one</b> of the following that identifies the SCA risk condition: <ul style="list-style-type: none"> <li>• H&amp;P, progress note, consult note, or discharge summary</li> <li>• ECG strip showing long QT or other abnormality</li> </ul>
3 MI or dilated cardiomyopathy with an EF $\leq$ 35%	MI or dilated cardiomyopathy	Attach <b>one</b> of the following that identifies and dates the diagnosis: <ul style="list-style-type: none"> <li>• H&amp;P, progress note, consult note, or discharge summary</li> <li>• ECG strip showing evidence of infarction</li> </ul>
	EF $\leq$ 35%	Attach <b>one</b> of the following that dates and reports results of EF testing: <ul style="list-style-type: none"> <li>• H&amp;P, progress note, consult note, or discharge summary</li> <li>• Report from echocardiogram or other test estimating the EF</li> </ul>
4 ICD explantation	ICD explantation	Attach <b>one</b> of the following that identifies and dates the explantation: <ul style="list-style-type: none"> <li>• H&amp;P, progress note, consult note, or discharge summary</li> </ul>
5 other high risk of life-threatening VT/VF	evidence of risk	Attach <b>one</b> of the following that identifies the risk condition: <ul style="list-style-type: none"> <li>• H&amp;P, progress note, consult note, or discharge summary</li> <li>• Test report supporting risk condition</li> </ul>