Aspira® Drainage System Discharge/Prescription Form—Urgent Physician Order

1. **Patient Name** _____ (First) _____ (Last) **Date of Birth** ____ / ____ / ____ (Month / Day / Year)

Phone: (_____) _____ – _____ **Patient Time Zone:** ☐ Eastern ☐ All other U.S. time zones

2. **Discharge Planner Contact**: _____ (First) _____ (Last) Phone: (_____) _____ – _____

3. **Discharge to** (select one):
☐ Home (No Nurse) ☐ Home Health Nurse ☐ Hospice ☐ SNF ☐ Hospital (pending D/C)
Agency Name: _____ Phone: (_____) _____ – _____
If discharge to Home Health Nurse, Hospice, or SNF

4. **Quantity of Aspira Drainage System Supplies to be Sent Home with Patient (select one):**
☐ 0 Drain/Dressings ☐ 5 Bags/Dressings ☐ 5 Bags/Dressings + Voucher ☐ 20 Bags/Dressings
☐ 4 Bottles/Dressings ☐ 4 Bottles/Dressings + Voucher

Prescription Information

5. **Quantity of Catheters Placed:**
☐ One catheter ☐ Two catheters (Bilateral catheter must be noted in the medical record. This selection will double quantity of supplies.)

6. **Primary Diagnosis—Location of Fluid (Select one):**
☐ J91.0 Malignant Pleural Effusion ☐ R18.0 Malignant Ascites ☐ Other diagnosis/ICD 10: _____
☐ J91.8 Unspecified Pleural Effusion ☐ R18.8 Other Ascites

7. **Secondary Diagnosis—Medical Condition Requiring Catheter Placement and Drainage (Select one):**
☐ C78.01 Lung Cancer (Right Lung) ☐ C50.911/C50.921 Breast Cancer (Right Breast) ☐ C56.1 Ovarian Cancer (Right Ovary)
☐ C78.02 Lung Cancer (Left Lung) ☐ C50.912/C50.922 Breast Cancer (Left Breast) ☐ C56.2 Ovarian Cancer (Left Ovary)
☐ C78.00 Lung Cancer (Unspecified) ☐ C50.919/C50.929 Breast Cancer (Unspecified) ☐ C56.9 Ovarian Cancer (Unspecified)
☐ Other diagnosis/ICD 10: _____

8. **Drainage Prescription—Aspira Drainage Kit (Select one):** PRN or As Needed are not acceptable answers.
Aspira Drainage Kit includes: 1000 mL vacuum bag or bottle, tubing, valve cap, siphon pump, slide clamp, adhesive strips, and alcohol pads.
☐ Drain once daily (30 kits/month) ☐ Drain every other day (15 kits/month) ☐ Other (specify): _____

9. **Dressing Prescription—Aspira Dressing Kit (Select one):** PRN or As Needed are not acceptable answers.
Aspira Dressing Kit includes: transparent film/dressing, adhesive strips, gloves, alcohol pads, split gauze, gauze pads, and a sterile sheet
☐ Dress once every 3 days (10 kits/month) ☐ Dress every other day (15 kits/month) ☐ Other (specify): _____

10. **Length of Need/Refills:** ☐ Patient Life **(max. 12 months)** ☐ 3 months ☐ 6 months ☐ 9 months

11. **Order Date:** ____ / ____ / ____

Physician Attestation

I certify with my signature that I am the physician named below. The information contained on this written order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the Aspira products prescribed by me. This order for Aspira products is reasonable and necessary for the diagnosis and treatment of the patient's illness. The patient and/or caregiver has been trained on the proper use of the Aspira products and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare or other insurance for post-payment review or audits.

PHYSICIAN NAME: _____ Phone: (_____) _____ – _____ NPI #: _____

X
PHYSICIAN SIGNATURE Date: _____ / _____ / _____

☐ I would like a call to confirm receipt of this referral and obtain a status for delivery.

12. **Facility/Hospital Name:** _____ **Facility Phone:** (_____) _____ – _____

Instructions for Fax Submission

Fax completed form along with the documents listed below to: **Eastern Time Zone,** 866–634–8166, **All other time zones,** 888–718–0633.
- **Patient Face Sheet** (containing current demographics and insurance)
- **Medical Record** (explicitly stating presence of Aspira Drainage Catheter and need for drain/dressing change)
- **Copy of Voucher** (if applicable)

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