Medical Order Form

ZOLL® LifeVest®

PLEASE COMPLETE ALL FIELDS

1) Patient Information and Condition

a) Patient Name (Print First and Last Name) _____

b) Date of Birth (MM/DD/YYYY) _____ / _____ / _____

c) Estimated Start Date (MM/DD/YYYY) _____ / _____ / _____

d) Estimated Length of Need: ❑ 6 months ❑ 5 months ❑ 4 months ❑ 3 months ❑ Other _____

Note: If left blank, the minimum length of 1 month will be applied, and a new order will be required to extend use.

e) Reason for LifeVest (Check One):

❑ Cardiac arrest due to VF or sustained VT

❑ Familial or inherited condition with SCA risk

❑ MI with an EF of ≤ 35%

❑ DCM (including NICM) with an EF of ≤ 35%

❑ ICD explantation

❑ Other condition with high risk of VT/VF (Describe) _____

Note: Documentation supporting Reason for LifeVest is required. Please see the following page for instructions.

2) LifeVest Settings *(Enter value for each setting. Default value will be applied if left blank)*

a) VT heart rate threshold	*b)* VF heart rate threshold	*c)* Treatment energy
Default: 150 BPM	**Default: 200 BPM**	**Default: 150 Joules, all five shocks**
☐	☐	*1st*____ *2nd*____ *3rd*____ *4th*____ *5th*____
(Increments of 10)	*(Increments of 10)*	*(Increments of 25 between 75J – 150J)*

3) Prescriber Information

a) Prescriber's Designated Contact Person _____

b) Contact Person's Phone Number (_____) – _____ – _____

c) **Prescriber Name** (Print First and Last Name) _____

d) **Prescriber Signature - *Do Not Stamp*** _____

e) **Signature Date** (MM/DD/YYYY) _____ / _____ / _____

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