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 (DD/MM/YYYY) _____ / _____ / _____

c) Estimated Start Date (DD/MM/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):

❑ Recent MI (<40 days) with an EF ≤35%
❑ Recent PCI (<90 days) with an EF ≤35%
❑ Recent CABG (<90 days) with an EF ≤35%
❑ DCM with Potential for Heart Improvement, and an EF ≤35%
❑ Class IV NYHA CHF with an EF ≤35%
❑ NICM with an EF ≤35%
❑ Other terminal illness with an EF ≤35%
❑ ICD Explantation
❑ Genetic (Brugada, Short QT, Long QT, etc.)
❑ Cardiac Arrest due to VF or Sustained VT
❑ Other condition with high risk of SCD not listed above (Describe) _____
❑ ICD delay; patient is indicated for ICD but surgery is delayed due to patient's condition
❑ Unknown

Ejection Fraction (EF)

_____ %

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

a) VT heart rate threshold

Default: 150 BPM

(Increments of 10)

b) VF heart rate threshold

Default: 200 BPM

(Increments of 10)

c) Treatment energy

Default: 150 Joules, all five shocks

*1st*_____ *2nd*_____ *3rd*_____ *4th*_____ *5th*_____

(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) **Hospital/Institution** _____

e) **Prescriber Signature — Do Not Stamp** _____

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

Phone 001 800 4008 0070

Fax 6807 1699

PDF LifeVest.Orders-SG@zoll.com

Submitting a Medical Order

1) Complete the LifeVest Medical Order Form. Please note that ***ALL FIELDS*** must be completed and the order form must be ***SIGNED AND DATED*** by the prescriber.

2) Submit completed Medical Order Form to ZOLL by fax to **6807 1699** or by email to **LifeVest.Orders-SG@zoll.com**

3) Once a complete order is received, ZOLL will contact your office to schedule a Patient Service Representative appointment.

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