

**Prescription and Request for Funding for an Additional BPAP Device**

**B-2**

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21, 22 and 27 of the *Health Information Act* and sections

33, 34, 39 and 40 of the *Freedom of Information and Protection of Privacy Act (FOIP)* for the purpose of providing and determining eligibility for health benefits under the *Alberta Aids to Daily Living and Extended Health Benefits Regulation.* If you have any questions about the collection of this information, you can contact Alberta Aids to Daily Living Program, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2 Telephone: 780-427-0731 Fax: 780-422-0968.

 Date submitted *(yyyy-mm-dd)*

1. Client's Name (Last, First)

PHN Date of Birth *(yyyy-mm-dd)* ***- -***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | AddressCity  |  Postal Code |  | Telephone Number |
| 2. | Respiratory Assessor (Last, First Name) |  |  |  |
|  | Designation: RRT OtherPhone |  | Fax | Facility Name |

3. Is client’s BPAP usage equal to or greater than 16 hours per day? Yes No

 If no, client is not eligible for a second BPAP.

4. Reason for requesting an additional BPAP

5. Current Diagnosis:

6. Prescribed BPAP Settings

Mode S *SIT* PC AVAPS

 IPAP min IPAP max EPAP Rate Rise Ti Vt Ramp 02

 Other

|  |  |  |
| --- | --- | --- |
| 7. | Prescribing Physician Name (Last, First) Phone |  Fax |
|  | Date *(yyyy-mm-dd)* |  Signature |
| 8. | Comments |  |