Alberta Government

Prescription and Request for Funding for an Additional BPAP Device

B-2

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Date submitted *(yyyy-mm-dd)* ______________

1. Client's Name (Last, First) ______________________________

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

   Address ______________________________

   City ______________ Postal code __________ Telephone Number ______________

2 Respiratory Assessor (Last, First Name)

   Designation: ☐ RRT ☐ Other ______________ Facility Name ______________

   Phone ______________________ Fax ______________________

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______ 0_2______

   Other

7. Prescribing Physician Name (Last, First) ______________________________

   Phone ______________________ Fax ______________________

   Date *(yyyy-mm-dd)* ______________ Signature ______________

8. Comments

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