

Government

**Prescription and Request for BPAP Funding for Pediatric Clients**

**B-PED**

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.

* Please read the instructions on page 3 prior to completing this form.
* This form is for Clients (age less than 18) who request ventilator support for respiratory insufficiency.

Date Submitted *(yyyy-mm-dd)*

Urgent for the following reason(s)

Client requires BPAP for hospital discharge or to prevent hospital (re)admission.

Client starts on BPAP and oxygen at the same time.

Other *(specify)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | Client's Name (Last, First)  PHN | |  | | |  | | | Date of Birth *(yyyy-mm-dd)* | | | | | |
|  | Address  City |  | | | Postal Code | | | Telep | | | | |
| 2. | Respiratory Assessor (Last, First Name) | | |  | | |  | | | |  | | |
|  | Designation RRT Other | | |  | | |  | | | | Facility Name | | |
|  | Phone | | |  | | | Fax | | | |  | | |
|  |  | |  | | |  | | | |  | |

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Telephone Number

3. If Client is in the hospital, provide hospital name and unit

Tentative discharge date *(yyyy-mm-dd)*

4. Client Contact Information (if appropriate)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Last Name |  |  | First Name |
| Phone#  Relationship to client: | Parent/Guardian | Other | Alternate Phone# |
| 5. | Current Diagnosis |  |  |  |

6. Summary of the clinical information supporting the request for home BPAP (attach supporting documents and/or sleep study with interpretation).

I Client's Name (Last, First) I PHN

7. Prescribed BPAP Settings

Mode S S/T PC AVAPS

IPAP min IPAP max EPAP Rate Rise Ti Vt Ramp O2

Other

8. Preferred BPAP Specialty Supplier

9. Does client require oxygen with the BPAP? Yes No

If yes, the oxygen Specialty Supplier will be the same as the BPAP Specialty Supplier wherever possible.

10. Prescribing Physician Name (Last, First)

Phone

Date *(yyyy-mm-dd)*

Fax

Signature

11. Comments

I Client's Name (Last, First)

**How to Complete the Prescription and Request Form for BPAP Funding for**

**Pediatric Clients**

This form is for Clients (age less than 18) who request ventilatory support for respiratory insufficiency.

1. Provide Client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card. Provide Client's address, including postal code and the contact number.

2. Provide the name, designation, facility and the contact information of the Respiratory Assessor who completes the request form. The Respiratory Assessor must ensure the information provided to be true and correct.

3. If Client is in the hospital, provide the name of the hospital, the station or unit number and Client's tentative discharge date.

4. Provide alternate Client contact information and the relationship of this person to the Client.

5. Provide current diagnosis.

6. Provide the Client's diagnosis and reason(s) for the BPAP funding request. Attach sleep study with interpretation and any other documents supporting the BPAP request.

7. Provide the data on the BPAP mode and settings for this request.

8. Provide preferred BPAP Specialty Supplier. It shall be based on Client's needs and Client's current relationship with the Specialty Supplier.

9. If oxygen is required with the BPAP, the oxygen Specialty Supplier will be the same as the BPAP Specialty Supplier wherever possible.

10. Provide the name, phone number, fax number and signature of the prescribing physician. No separate BPAP prescription is required if this request form is signed by the prescribing physician.

11. Provide comments if any.