 Government

**Prescription and Request for BPAP Funding for Clients Requiring a Restart of BPAP Therapy**

**B-RESTART**

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.

* This form is completed for Clients who were previously discontinued from BPAP therapy and are now requesting funding to restart BPAP therapy.
* This form must be signed by the physician to confirm agreement with the BPAP therapy restart and also to confirm that the Client still requires BPAP therapy. The physician must be a certified pulmonologist or a physician trained in sleep disordered breathing.

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 Telephone Number

2. Respiratory Assessor (Last, First Name)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Designation RRT Other Facility Name  Phone Fax | | | |  | Fax |  | |  | |
| 3. | If Client is in the hospital, provide hospital name and unit  Tentative discharge date *(yyyy-mm-dd)* |  |  |  | | | |  | |
|  |  |  |  |  | | | |  | |
| 4. | Current Diagnosis |  |  |  | | | |  | |

5. BPAP therapy was previously discontinued due to the following reason(s)

a) Client was not compliant with the BPAP therapy.

b) Client could not tolerate the BPAP therapy.

c) Client was placed in a long-term care facility or moved out of the province.

d) Other (specify)

6. Rationale to restart the BPAP therapy

7. If the reason for previous BPAP therapy discontinuation is due to 5(a) or 5(b), has there been a discussion with the Client to confirm that the Client is committed to achieving compliance with the BPAP therapy?

Yes No (Client is not eligible for BPAP funding restart)

8. Prescribed BPAP Settings:

Mode S S/T PC AVAPS

IPAP min IPAP max EPAP Rate Rise Ti Vt Ramp 02

Other

9. Preferred BPAP Specialty Supplier

1o. Prescribing Physician Name (Last, First)

Phone Fax

Date *(yyyy-mm-dd)* Signature

* This form must be signed by the physician to confirm agreement with the BPAP therapy restart and to confirm that the Client still requires BPAP therapy.

11. Comments