 Government

**Prescription and Request for BPAP Funding for Adults with Sleep Disordered Breathing**

**B-SDB**

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 18 or older) who have nocturnal respiratory insufficiency attributed to sleep disordered breathing (including sleep apnea or hypoventilation related to obesity or medication) who are requesting **BPAP** funding.

* If 02 is requested to be used with the **BPAP,** the referrer does not need to create a separate 02 funding authorization.

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

5. Date of the most current full PFT *(yyyy-mm-dd)* (attach copy)

FEV1 liters ( % pred) FVC liters ( % pred) FEV1/FVC ratio BMI Does the Client have severe Chronic Obstructive Pulmonary Disease (COPD)? Yes No

6. Current medications

7. Client should meet ALL of the following requirements for BPAP funding

1. Significant decrease/elimination of respiratory events Yes No b) Decrease of peak TcCo2 level Yes No
2. Improved oxygenation with BPAP Yes No

8. Prescribed BPAP Settings

Mode S S/T PC AVAPS

IPAP min IPAP max EPAP Rise Rate Ti Vt Ramp 02

Other

9. Preferred BPAP Specialty Supplier

10. Does Client require 02 with the BPAP? Yes No

If yes, the 02 Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.

11. Prescribing Physician Name (Last, First)

Phone

Date *(yyyy-mm-dd)*

Fax

Signature

* BPAP prescription must be signed by a certified pulmonologist or a physician trained in sleep disordered breathing.

12. Comments

**How to Complete the Prescription and Request Form for BPAP Funding for Adults with Sleep Disordered Breathing (No PSG)**

**This form is for Clients (age 18 or older) who have nocturnal respiratory insufficiency attributed to sleep disordered breathing (including sleep apnea or hypoventilation related to obesity or medication) who are requesting BPAP funding. If 02 is requested to be used with the BPAP and/or hypoventilation related to medication use, the referrer does not need to create a separate 02 authorization.**

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 Respiratory Assessor who completes the request form.

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 Client's current diagnosis.

5. Provide a copy of the most current interpreted full Pulmonary Function Test. Enter FEV1 actual value in liters and its% predicted, actual ratio of FEV1 to FVC and body mass index (BMI). If the Client has severe primary Chronic Obstructive Pulmonary Disease (COPD) and does not have sleep disordered breathing, do not submit this request to RBP.

6. Provide a complete current medication list. If Client has a long list of medications or additional space is required, attach a list.

7. In order to qualify for BPAP funding, the data entered in #7 should meet all of the following requirements:

* 1. Significant decrease or elimination of respiratory events
  2. Decrease of peak TcCO2 level
  3. Improved oxygenation with BPAP

8. Provide the data of the BPAP mode and settings (including 02) on this request.

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

10. If 02 is approved with the BPAP, the 02 Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.

11. 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.

12. Provide comments if any.