Alberta Government

Request for Pre-Approval of Tracheostomy Tube

PATT

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Request for Special/Custom Tracheostomy Tube

Date: _____

Client's Name (Last, First): _____ PHN: _____

Description (Make and Size) of the Specialty Tracheostomy Tube: _____

Part/Catalogue Number: _____

Specialty Supplier: _____

Additional Pertinent Information: _____

Request for:

A. Number of Tracheostomy Tube(s) per 12 months: _____
B. Price of Each Tracheostomy Tube: _____
C. Total Amount: _____

AADL Use Only:

☐ Approved Amount: _____

Signature: _____

Date: _____