Alberta Government

Prescription and Request for BPAP Funding for Pediatric Clients

B-PED

- 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.

This request needs to be uploaded to the Alberta Blue Cross Online Health Portal for funding to be considered.

☐ Urgent for the following reason(s). **Please phone the Alberta Blue Cross AADL Provider Line 587-756-8629**

☐ 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 _____

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# _____ Alternate Phone# _____

Relationship to ☐ Parent/Guardian ☐ Other _____

5. Current Diagnosis

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

Client's Name: _____ PHN: _____

7. Prescribed BPAP Settings

Mode ☐ S ☐ S/T ☐ PC ☐ AVAPS ☐ iVAPS ☐ No substitutions

IPAP min ___ IPAP max ___ EPAP ___ Rate ___ Rise ___ Ti ___ Vt ___ Ramp ___ O_2 ___

Height (if prescribing iVAPS): _____ 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 _____ Fax _____

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

11. Comments

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.