Alberta Government

Respiratory Therapy BPAP Communication Tool

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21 and 22 of the *Health Information Act,* sections 33 and 34 of the *Freedom of Information and Protection of Privacy Act (FOIP)* and the *Alberta Aids to Daily Living and Extended Health Benefits Regulations* for the purpose of the determination eligibility for an AADL benefit. 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.

Attach completed form to the BPAP device Record changes to prescription or equipment on the following page

Client Information

Client Name ______________________________ PHN ____________________

Address ____

Diagnosis ☐ OSA ☐ Obesity Hypovenventilation ☐ Neuromuscular *(specify)* ____________________

☐ Spinal Cord Injury ☐ Other *(specify)* ______________________________

History of NIV Therapy ☐ Yes List details or comments ______________________________

Other Respiratory History or Reason for Transfer *(specify)* ______________________________

Initial Settings

☐ S ☐ S/T ☐ PC IPAP min: ________ IPAP max: ________ EPAP: ________ Back-Up Rate: ________

Rise: ________ Ti: ________ 02: ________ ☐ AVA PS Vt: ________ Ramp: ________ Other: ____________

Setup by *(last, first* name): ______________________________ Date *(yyyy-mm-dd):* ____________________

NIV Titration ☐ Outpatient ☐ Sleep Lab ☐ In-hospital *(specify)* ____________________ ☐ Other

Interfaces Trialed *(specify size/model)* ☐ Full face ☐ Nasal ☐ Other

Current Interface *(specify size/model)* ☐ Full face ☐ Nasal ☐ Other

☐ Independent with donning and doffing and cleaning
☐ Caregiver support required ☐ Donning ☐ Doffing ☐ Cleaning
☐ Other *(specify)*

Specific concerns (communication/cognition)

Follow-up Contact Information

Physician *(last, first name)* ______________________________ Phone ____________________
AHS Home Care RT *(last, first name)* ______________________________ Phone ____________________
BPAP Provider *(name)* ______________________________ Phone ____________________

☐ Clinic Involvement (i.e. ALS, Calgary Sleep Lab, etc.) *specify* ______________________________

Information Completed by:

Name *(last, first)* and Designation	**Phone**	**Date** *(yyyy-mm-dd)*

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Client Name	PHN

Other Relevant Information:

Plan

Complete the following to reflect any changes in BPAP prescription or BPAP equipment.

Date of Current Prescription (yyyy-mm-dd)

Prescribing Physician (last, first name) Phone

☐ Change in BPAP Prescription ☐ Change of Equipment Date of Change *(yyyy-mm-dd)*

Changes made by *(last, first name)* Phone

☐ RRT ☐ Other *(specify)*

☐ AHS Facility *(specify)* ☐ BPAP Provider *(specify)*

☐ Community/Homecare *(specify)*

Settings

☐ S ☐ S/T ☐ PC IPAP min: IPAP max: EPAP: Back-Up Rate:

Rise: Ti: O_2: ☐ AVAPS Vt: Ramp: Other:

Complete the following to reflect any changes in BPAP prescription or BPAP equipment.

Date of Current Prescription (yyyy-mm-dd)

Prescribing Physician (last, first name) Phone

☐ Change in BPAP Prescription ☐ Change of Equipment Date of Change *(yyyy-mm-dd)*

Changes made by *(last, first name)* Phone

☐ RRT ☐ Other *(specify)*

☐ AHS Facility *(specify)* ☐ BPAP Provider *(specify)*

☐ Community/Homecare *(specify)*

Settings

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Changes made by *(last, first name)* Phone

☐ RRT ☐ Other *(specify)*

☐ AHS Facility *(specify)* ☐ BPAP Provider *(specify)*

☐ Community/Homecare *(specify)*

Settings

☐ S ☐ S/T ☐ PC IPAP min: IPAP max: EPAP: Back-Up Rate:

Rise: Ti: O_2: ☐ AVAPS Vt: Ramp: Other:

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