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This form is completed by the BPAP Specialty Supplier with input from the Client's physician, clinician in the sleep clinic or other healthcare professionals when appropriate. It is completed if the Client has not achieved BPAP compliance of at least 4 hours per day for 70% of the time.

1. Client's Name (Last, First) \_\_\_\_\_ PHN \_\_\_\_\_

2. Details of the comprehensive plan

a) Barriers to treatment

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> 1 Lack of understanding of benefits | <input type="checkbox"/> 5 Poor mask fit/ air leak                | <input type="checkbox"/> 9 Chronic sinus congestion     |
| <input type="checkbox"/> 2 Insomnia                          | <input type="checkbox"/> 6 Dyssynchrony                           | <input type="checkbox"/> 10 Pressure ulceration or skin |
| <input type="checkbox"/> 3 Poor tolerance of high BPAP       | <input type="checkbox"/> 7 Anxiety or claustrophobic              |   |
| <input type="checkbox"/> 4 Dry stuffy nose                   | <input type="checkbox"/> 8 Gastric distention from swallowing air |   |

For other (please specify)

b) Detail the activities (with dates) that have been done so far to achieve BPAP compliance

c) Potential solutions

d) Timeline proposed to resolve the barrier(s)

3. Signatures

\_\_\_\_\_  
Name with Designation (Please PRINT)

\_\_\_\_\_  
Date (yyyy-mm-dd)

\_\_\_\_\_  
Signature of the Clinician

\_\_\_\_\_  
Name (Please PRINT)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date (yyyy-mm-dd)

\_\_\_\_\_  
Signature of Client/Individual for Client

Note: Client or individual for Client's signature is required. If it is missing, BPAP funding extension request will not be processed.

4. Additional Comments