Alberta Government

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

B-SDB

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- 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 0_2 is requested to be used with the **BPAP,** the referrer does not need to create a separate 0_2 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 _____ Facility 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

   a) Significant decrease/elimination of respiratory events ☐Yes ☐No b) Decrease of peak $TcCo_2$ level ☐Yes ☐No

   c) 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 _____ O_2 _____

   Other

9. Preferred BPAP Specialty Supplier _____

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

    If yes, the O_2 Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.

11. Prescribing Physician Name (Last, First) _____

    Phone _____ Fax _____

    Date *(yyyy-mm-dd)* _____ 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 0_2 is requested to be used with the BPAP and/or hypoventilation related to medication use, the referrer does not need to create a separate 0_2 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:
   a. Significant decrease or elimination of respiratory events
   b. Decrease of peak $TcCO_2$ level
   c. Improved oxygenation with BPAP

8. Provide the data of the BPAP mode and settings (including 0_2) 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 0_2 is approved with the BPAP, the 0_2 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.