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: ______________________________

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