

**Respiratory Therapy BPAP Communication Tool**

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| 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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(2014/07/01)

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Respiratory Benefits Program

Respiratory Therapy BPAP Communication Tool

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| Client Name |
| Other Relevant Information: \_ |
| Plan |



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

Date of Current Prescription (yyyy-mm-dd)

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | |
| 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: : | O2: | AVAPS Vt: | Ramp: | Other: |

Date of Current Prescription (yyyy-mm-dd)

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Date of Current Prescription (yyyy-mm-dd)

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| S | S/T | PC | IPAP min: | IPAP max: | EPAP: | | Back-Up Rate: | |
| Rise: |  | Ti: | 02: | AVAPS Vt: | Ramp: | | Other: | |

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