SOCIAL DEVELOPMENT
Health Services Program
P.O. Box 5500, Fredericton, N.B., E3B 5G4
Toll Free: 1-844-551-3015
Fax: (506) 453-3960

DÉVELOPPEMENT SOCIAL
Programme des services de santé
C.P. 5500, Fredericton N.-B., E3B 5G4
Sans Frais: 1-844-551-3015
Télécopieur: (506) 453-3960

Clear / Effacer

APPLICATION FOR VENTILATION EQUIPMENT

PART A : CLIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH
ADDRESS /	CITY, TOWN, VILLAGE	POSTAL CODE
TELEPHONE	HEALTH CARD NUMBER	PRIVATE INSURANCE
		Yes / Oui ☐ No / Non ☐

PART B : PRESCRIBER & RESPIRATORY THERAPIST INFORMATION

RESPIROLOGIST ☐ INTENSIVIST ☐ PHYSIATRIST ☐

PRESCRIBING PHYSICIAN CONTACT INFORMATION

NAME : _____ SIGNATURE : _____

TELEPHONE : _____ DATE : _____

RESPIRATORY THERAPIST CONTACT INFORMATION

NAME / NOM : _____ TELEPHONE _____

PART C: DIAGNOSIS

- ☐ ALS / Motor Neuron Disease
- ☐ Spinal Cord Injury / Tetraplegia
- ☐ Kyphoscoliosis
- ☐ Polio / Post Polio
- ☐ Spinal Muscular Atrophy
- ☐ Duchenes Muscular Dystrophy
- ☐ Central Hypoventilation
- ☐ Other Neuromuscular Degenerative Disease evolving to ventilation support because of clinical presentation:

_____

PART D: CLINICAL DATA

* Mandatory for cough assist <200 l/min

FVC _____
*Peak Cough Flow _____
SNIP _____
MIP / MEP _____
Blood Gas _____
Oximetry _____

IPAP:
EPAP:
Respiratory Rate:

Notes:

PART E : PRESCRIPTION PHASE

Phase I	☐	Early intervention: patient requires nocturnal BPAP with AVAPS. Lung Recruitment Volume exercises taught. No significant bulbar involvement
Phase II	☐	BPAP with AVAPS nocturnal and daytime PRN use. Swallow/ cough impairment. Oral aspirator, mechanical in/ ex sufflator for airway clearance
Phase III	☐	BPAP with AVAPS required 18-22 hours daily; options for palliation or extended life discussed and chosen by patient.
Phase IV a	☐	Palliation; patient choose not to be intubated; BPAP with AVAPS continuous, in/ex sufflation as per patient choice.
Phase IV b	☐	Elective intubation/ tracheotomy, with planned volume or pressure controlled ventilation
Phase IV c	☐	Emergency intubation; patient chooses intubation as last resort; volume or pressure controlled ventilator with initial non-invasive interface; plan for future elective or emergency intubation.

PART F : SERVICE PROVIDER INFORMATION

TO BE COMPLETED BY AN AUTHORISED VENDOR ONLY

CONTACT NAME: _____ TELEPHONE : _____ FAX : _____

VENDOR : _____

VENDOR IDENTIFICATION NUMBER :

PART G: EQUIPMENT PRESCRIBED

EQUIPMENT TO BE PURCHASED			EQUIPMENT TO BE RENTED		
Cough Assist Machine (Mechanical Insuffulator-Exsufflator)	☐	$	Bi-Level with VAPS	☐	$
SPO^2 monitor	☐	$	Ventilator-non invasive	☐	$
Heated humidifier	☐	$	Ventilator	☐	$
O^2 saturation monitor	☐	$	Table Top Sat Monitor	☐	$
Oral/Endotracheal aspirator	☐	$		☐	$
	Total	0.00 $		Total	0.00 $

SUPPLIES TO BE PROVIDED BY VENDOR ON A MONTHLY OR ANNUAL BASIS

Product Details (Brand name, type of item and serial number where applicable)	Cost (EA)	Quantity	Monthly	Annual
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
Service Dates: Total	0.00 $			

BEFORE SUBMITTING FOR YOUR TRIAL OR PURCHASE, PLEASE VERIFY THE FOLLOWING

All necessary documentation specified in the Health Services Guidelines are included with this application.	☐ Y / O	☐ N / N
The client, and other household members, have received education relevant to the equipment provided and are willing to comply with the treatment plan prescribed, including smoking cessation.	☐ Y / O	☐ N / N

Vendor Signature :
Signature du fournisseur : _____ Date : _____

Please include a copy of this document with your initial request for payment on the Health Services Claim Form. Thank you.

FOR OFFICE USE ONLY

APPROVED ☐ REFUSED ☐ PENDING INFO ☐

APPROVAL NUMBER TRIAL ☐ PURCHASE ☐

Administrator
Administrateur _____ Date : _____

EXPIRES:

Comments

REGISTERED

DATE : _____