

CLIENT INFORMATION				
Name		Health Card #	Medicare #	
DOB: D/J M Y/A		Phone:	Fax/email:	
Address		Parent/Guardian Name (if applicable)		
PRESCRIBER INFO				
<input type="checkbox"/> Respiriologist <input type="checkbox"/> Intensivist <input type="checkbox"/> Physiatrist	Prescribing Physician Name:		Prescribing Physician Address:	
	Prescribing Physician Phone:		Family Physician Name:	
DIAGNOSIS		CLINICAL DATA *mandatory for cough-assist <200 l/min		
<input type="checkbox"/> ALS/Motor Neuron Disease <input type="checkbox"/> Duchenes Muscular Dystrophy <input type="checkbox"/> Spinal Cord Injury/Tetraplegia <input type="checkbox"/> Central Hypoventilation <input type="checkbox"/> Kyphoscoliosis <input type="checkbox"/> Polio/Post-polio <input type="checkbox"/> Spinal Muscular Atrophy <input type="checkbox"/> Other Neuromuscular Degenerative Disease <small>evolving to ventilation support because of clinical presentation</small>		FVC:	Blood Gas:	Oximetry:
		*Peak Cough Flow:		
		SNIP:		
		MIP/MEP:		
		Notes:		
EQUIPMENT PRESCRIBED		PRESCRIPTION PHASE (for patients with progressive disease)		
<input type="checkbox"/> BiPAP with AVAPS <input type="checkbox"/> Cough Assist Machine (Mechanical Insufflator-Exsufflator) <input type="checkbox"/> Ventilator – non-invasive <input type="checkbox"/> Ventilator - invasive <input type="checkbox"/> Oral/Endotracheal Aspirator <input type="checkbox"/> SPO2 monitor <input type="checkbox"/> Heated humidifier <input type="checkbox"/> O2 Saturation Monitor	<input type="checkbox"/> Phase I	Early intervention; patient requires nocturnal BiPAP with AVAPS. Lung Volume Recruitment exercises taught. No significant bulbar involvement.		
	<input type="checkbox"/> Phase II	BiPAP with AVAPS nocturnal and daytime PRN use. Swallow/cough impairment. Oral aspirator, mechanical in/ex-sufflator for airway clearance.		
	<input type="checkbox"/> Phase III	BiPAP with AVAPS required 18-22 hours daily; options for palliation or extended life discussed and chosen by patient		
	<input type="checkbox"/> Phase IVa	Palliation; patient chooses not to be intubated; BiPAP with AVAPS continuous, in/ex sufflation as per patient choice		
EQUIPMENT PROVIDER		<input type="checkbox"/> Phase IVb	Elective intubation/tracheostomy, with planned volume or pressure controlled ventilation	
Company Name:		<input type="checkbox"/> Phase IVc	Emergent intubation; patient chooses intubation as last resort; volume or pressure controlled ventilator with initial non-invasive interface; plan for future elective or emergent intubation	
Location:				
Contact Name:				
Phone #:				
Fax #				
Respiratory Therapist(s):		Name and Contact #:		



**Application for Ventilation Equipment
Social Development**

Signature of Prescribing Physician

Date

Please present this application form to the nearest regional Social Development office, along with an estimate for the prescribed intervention(s) from the equipment provider indicated above.