

Alberta Aids to Daily Living (AADL) Client Responsibility Form

Clients receiving respiratory benefits must meet the current AADL respiratory eligibility criteria.

Responsibilities

AADL clients must be informed and agree to:

1. Pay the cost share portion of the equipment to the respiratory Specialty Supplier if you are not exempt from cost sharing;
2. Notify AADL and the respiratory Specialty Supplier if you move to a different address, no longer require the equipment, move out of province, move to a long-term care facility, are admitted to hospital or change your family physician;
3. Inform the Specialty Supplier if you are traveling out of the province, the dates and the destination. The Specialty Supplier may help with your oxygen arrangements. Submit your receipts indicating full payment to AADL Respiratory Unit. If the currency is not in Canadian dollars, submit currency rate at the time of travel. You will be reimbursed at the daily rate of \$9.89/\$10.81 for urban/rural locations if you are cost share exempt. The maximum reimbursed daily rate is \$8.16/\$8.93 for urban/rural locations if you are not cost share exempt;
4. Contact the AADL Respiratory Unit at (780) 422-8786 if you wish to change your Specialty Supplier;
5. Pay the respiratory Specialty Supplier for the disposable supplies such as oxygen tubing, nasal cannula, humidifier bottles, etc. These items are not covered by AADL;
6. Follow the fire safety guidelines if you are on oxygen. Oxygen clients are advised never to smoke when using their oxygen equipment. Others are advised to keep 5 feet away with lit cigarettes. If your smoking habit endangers yours or others' safety, the Specialty Supplier may discontinue your oxygen therapy and AADL will support this action;
7. Cooperate in doing the required testing as arranged by the respiratory Specialty Supplier or physician for oxygen funding to be continued. If testing is not done prior to the oxygen expiry date, your Specialty Supplier may bill you for the days that are not covered by AADL;
8. Take good care of the equipment you have been supplied with. It is your responsibility to replace any equipment that is lost, stolen or damaged;
9. Show no physical or verbal abuse to the Specialty Supplier or their staff. Failure to comply may result in the Specialty Supplier removing their equipment and services;
10. Sign the Client Declaration Form.

Signature of the Client: _____ **Date:** _____

Alberta Aids to Daily Living (AADL) Respiratory Specialty Supplier Change Form

Changeover Date (yyyy/mm/dd): _____/_____/_____

New Specialty Supplier: _____

Current Specialty Supplier: _____

Client Name: (Last) _____ (First) _____

Personal Health Number: _____

Auth Form No: _____ O₂ Status: _____

Catalogue No: _____ Region: _____

O₂ Auth Expiry Date (yyyy/mm/dd): _____/_____/_____

Client Address: _____

Phone: _____

100% AADL Cost Share Cost Share Exempt (reached \$500 for this benefit year)

Comment: _____

AADL Signature: _____

Date of Intake (yyyy/mm/dd): _____/_____/_____

The personal information provided on this form is collected under the authority of the Public Health Act (RSA 2000) and the Alberta Aids to Daily Living and Extended Health Benefits Regulation (236/1985) and managed in accordance with the Freedom of Information and Protection of Privacy Act (RSA 2000). The information will be used to change vendors for oxygen funding. If you have any questions about the collection of this information, you can Disability Supports Division, Health Related Supports, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta, T5J 0Z2. Telephone 780-427-0731. Fax: 780-422-0968.

2005/05/01 (Revised 2010/07/29, 2011/05/04)

Alberta Aids to Daily Living (AADL) Request for AADL Oxygen Funding

Respiratory Specialty Supplier _____ Branch _____ Current Status _____

Submitted by (First Name) _____ Date Submitted (yyyy/mm/dd) ____/____/____

Client's Name (Last, First) _____ PHN _____

Auth # for O₂ (if applicable) _____ Expiry Date (yyyy/mm/dd) ____/____/____

Diagnosis _____ Palliative

Oximetry Date (yyyy/mm/dd) ____/____/____ (RA SpO₂: Rest ____% OE ____% PE ____%)
On Exertion Post Exertion

Spirometry/PFT Date (yyyy/mm/dd) ____/____/____ HT ____ (cm/in) WT ____ (kg/lb) BMI ____

FEV1 = ____ l (____% Pred) FEV1/FVC = ____% DOB (yyyy/mm/dd) ____/____/____

CPAP/BPAP Yes (____ cmH₂O Rate ____ O₂ ____ lpm) No

Request for:

EOT (long-term/short-term x ____ months) Testing Date (yyyy/mm/dd): ____/____/____

Palliative (start/extension) x ____ months

Cardiac Palliative oxygen funding

Acceptance of oximetry as qualifying data

Short-term oxygen funding x ____ months

Acceptance of ABG result dated ____/____/____
(pH ____ PaCO₂ ____ PaO₂ ____ HCO₃ ____ or B.E. ____ Sat ____%)

Approval of set-up dated ____/____/____ (Resting SpO₂ = ____%)

Gap in funding or waiving gap in funding

For AADL Use Only

THIS IS NOT A PRESCRIPTION

Approved for long-term O₂ funding (Reference # _____) Funding Not Approved

Approved for short-term O₂ funding (Reference # _____)

New Expiry Date ____/____/____ New Auth Type _____

Gap in Funding From _____ to _____ (Exclusive)

Request Specialty Supplier to Submit:

- | | |
|---|---|
| <input type="checkbox"/> 1. Interpreted Full PFT (with BMI) | <input type="checkbox"/> 4. Recent Hospital Discharge Summary |
| <input type="checkbox"/> 2. Recent/Follow-Up Respiratory Assessment | <input type="checkbox"/> 5. Internist or Pulmonologist Consultation Report |
| <input type="checkbox"/> 3. Sleep Study: Level 1/Level 3/Oximetry | <input type="checkbox"/> 6. Sleep Study: Level 3 on Room Air with CPAP/BPAP |

Comment: _____

Signature of AADL
Respiratory Consultant _____ Dated (yyyy/mm/dd) ____/____/____

Alberta Aids to Daily Living (AADL) Request for AADL O₂ Funding: RH4 or RH2

1. Respiratory Specialty Supplier _____ Branch _____
2. Client's name (last, first) _____ PHN _____
3. Auth # for O₂ _____ Expiry date (yyyy/mm/dd) ____/____/____ Current status _____
4. Diagnosis _____
5. Date of recent ABG (yyyy/mm/dd) ____/____/____ (attach copy)
pH _____ PaCO₂ _____ PaO₂ _____ HCO₃ _____ (or B.E. _____) Sat _____
6. Date of full Pulmonary Function Test (yyyy/mm/dd) ____/____/____ (attach copy)
FEV1 _____ liters _____% pred FEV1/FVC ratio _____ BMI _____ DLCO adj _____% pred
TLC _____% pred VC _____% pred FRC _____% pred RV _____% pred
7. On APAP/CPAP/BPAP (please circle) ____ cmH₂O IPAP/EPAP ____ Rate ____ O₂ ____ lpm No
The prescribed therapy is based on L-1 sleep study L-3 sleep study other _____
Start date (yyyy/mm/dd) ____/____/____ Supplier name: _____
8. Prescribing physician (last, first name) _____
Phone () _____ Fax () _____
9. Submitted by (last, first name) _____
Phone () _____ Fax () _____
Signature _____ Dated (yyyy/mm/dd) ____/____/____
By signing this, I verify all information in this document to be true and correct.

For AADL Use Only

THIS IS NOT A PRESCRIPTION

Approved for long-term O₂ funding (Reference # _____) Funding Not Approved

Approved for short-term O₂ funding (Reference # _____)

New Expiry Date ____/____/____ New Auth Type _____

Gap in Funding From: _____ to _____ (Exclusive)

Request Specialty Supplier to Submit:

- | | |
|--|--|
| <input type="checkbox"/> 1 Repeat ABG | <input type="checkbox"/> 4 Recent/follow-up respiratory assessment |
| <input type="checkbox"/> 2 Medication list | <input type="checkbox"/> 5 Internist/Pulmonologist Consultation Report |
| <input type="checkbox"/> 3 L-1/L-3 sleep study with interpretation | <input type="checkbox"/> 6 APAP/CPAP/BPAP compliance download |

Comment _____

Signature of AADL _____ Dated (yyyy/mm/dd) ____/____/____

Alberta Aids to Daily Living (AADL) Request for AADL O₂ Funding: RH6 or RH5

1. Respiratory Specialty Supplier _____ Branch _____
2. Client's name (last, first) _____ PHN _____
3. Auth # for O₂ _____ Expiry date (yyyy/mm/dd) _____/_____/_____ Current status _____
4. Current medication _____
5. Date of recent ABG (yyyy/mm/dd) _____/_____/_____ (attach copy)
pH _____ PaCO₂ _____ PaO₂ _____ HCO₃ _____ (or B.E. _____) Sat _____
6. Oximetry Date (yyyy/mm/dd): _____/_____/_____ (RA SpO₂: Rest _____% OE _____% PE _____%)
On Exertion Post Exertion
7. Date of recent full Pulmonary Function Test (yyyy/mm/dd) _____/_____/_____ (attach copy)
FEV1 _____ liters _____% pred FEV1/FVC ratio _____ BMI _____ DLCO adj _____% pred
TLC _____% pred VC _____% pred FRC _____% pred RV _____% pred
8. Level 1/Level 3 sleep study with interpretation (attach copy) Yes No
Date of study (yyyy/mm/dd): _____/_____/_____
9. Compliance of CPAP/BPAP (attach 1-2 page summary) Yes No
10. Prescribing physician (last, first name) _____
Phone () _____ Fax () _____
11. Submitted by (last, first name) _____
Phone () _____ Fax () _____
Signature _____ Dated (yyyy/mm/dd) _____/_____/_____
By signing this, I verify all information in this document to be true and correct.

For AADL Use Only

THIS IS NOT A PRESCRIPTION

Approved for long-term O₂ funding (Reference # _____) Funding Not Approved

Approved for short-term O₂ funding (Reference # _____)

New Expiry Date _____/_____/_____ New Auth Type _____

Gap in Funding From: _____ to _____ (Exclusive)

Comment _____

Signature of AADL _____ Dated (yyyy/mm/dd) _____/_____/_____

Alberta Aids to Daily Living (AADL) Request for Nocturnal Oxygen Funding for Adults with Severe Lung Disease

This form is for clients (age ≥ 18) who do NOT have sleep disordered breathing and do NOT require CPAP/BPAP.

Please read the instructions on page 2 prior to completing this form.

1. Client's name (last, first): _____

PHN: _____ Date of birth (yyyy/mm/dd): ____/____/____

2. Date of recent interpreted full Pulmonary Function Test (yyyy/mm/dd): ____/____/____ (attach copy)

a) Severe pulmonary disease Yes No

b) BMI < 37 or BMI ≥ 37 and Level 1 study has been done Yes No

If "No" to any of the above questions, do not submit this request to AADL as client is not eligible for nocturnal O₂ funding.

3. Pertaining to Level 1 or Level 3 sleep study (attach sleep study and its interpretation)

Date of study (yyyy/mm/dd): ____/____/____

a) Sleep study is technically adequate & free of excessive artifact Yes No

b) No evidence of Sleep Disordered Breathing Yes No

c) AHI or RDI < 10 Yes No

d) At least 1 episode of SpO₂ ≤ 83% for 5 continuous minutes Yes No

If "No" to any of the above questions, do not submit this request to AADL as client is not eligible for nocturnal O₂ funding.

4. Prescribing/attending physician (last, first name): _____

Phone: () _____ Fax: () _____

5. Submitted by (last, first name): _____ From (facility): _____

Phone: () _____ Fax: () _____

Signature: _____ Dated (yyyy/mm/dd): ____/____/____

By signing this, I verify all information in this document to be true and correct.

For AADL Use Only

This is **NOT** a prescription

Approved for ND O₂ funding (Reference #: _____) Funding Not Approved

Approved for NDS O₂ funding x _____ months (Reference #: _____)

Set-up date (yyyy/mm/dd): ____/____/____ Expiry date (yyyy/mm/dd): ____/____/____

Gap in funding from: _____ to _____ (Exclusive)

Comment: _____

AADL Signature: _____ Dated (yyyy/mm/dd): ____/____/____

How to Complete the Request Form for Nocturnal Oxygen Funding for Adults with Severe Lung Disease

This form is for clients (age ≥ 18) who have lung disease but do NOT have sleep disordered breathing and do NOT require CPAP/BPAP.

1. Provide client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card.
2. Provide a copy of an **interpreted** full Pulmonary Function Test (PFT) which has been done within a year from the application date. Pertaining to the full PFT results and interpretation, client must have:
 - a) Severe pulmonary disease, and
 - b) Body mass index (BMI) of less than 37. If BMI is greater than or equal to 37, a level 1 sleep study must have been done.

Please do not submit this request to AADL if any of the above requirements are not met.

3. Provide a copy of an **interpreted** Level 3 or Level 1 sleep study which has been done within a year from the application date. Pertaining to the sleep study:
 - a) Must include at a minimum, a continuous recording of oxygen saturation, heart rate, and a direct measurement of airflow or nasal pressure. Technical quality must be good and free of excessive artifact,
 - b) Must indicate no evidence of Sleep Disordered Breathing,
 - c) Apnea Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is less than 10,
 - d) Must have at least one episode of SpO₂ less than or equal to 83% for 5 continuous minutes

Please do not submit this request to AADL if any of the above requirements are not met.

4. Provide name, phone and fax numbers of the prescribing or attending physician(s). AADL will fax a copy of the outcome of this request to the specified physician(s).
5. This form has to be reviewed, dated and signed by a RRT or healthcare professional to ensure the information provided in this request is true and correct. Provide printed name, facility and contact information for the RRT or healthcare professional who signed the form.

Submit the completed form and all appropriate test results to **AADL at (780) 638-3254** with all accompanying data for prior approval.

Alberta Aids to Daily Living (AADL) Request for Short-Term Nocturnal Oxygen Funding for Adults with Sleep Disordered Breathing

This form is for clients (age ≥ 18) with sleep disordered breathing who request oxygen with CPAP/BPAP and do NOT qualify for oxygen funding based on resting hypoxemia criteria. Please read the instructions on page 2 prior to completing this form.

- Client's name (last, first): _____
PHN: _____ Date of birth: (yyyy/mm/dd): ____/____/____
- Most recent Level 1 sleep study done within last 3 years: Yes No
If "No" to the above question, do not submit this request to AADL as repeat Level 1 study is required.
- Pertaining to Level 1 sleep study (attach sleep histogram and interpretation)
Date of study (yyyy/mm/dd): ____/____/____
 - AHI < 10 with CPAP/BPAP Yes No
 - Raw data $SpO_2 \leq 85\%$ on room air with CPAP/BPAP Yes No
 - Evidence of $SpO_2 > 85\%$ on O_2 with CPAP/BPAP Yes NoIf "No" to ANY of the above questions, do not submit this request to AADL as client is not eligible for nocturnal O_2 funding.
- Prescribed CPAP/BPAP: CPAP ____ cmH_2O IPAP/EPAP ____ Rate ____ O_2 (lpm) ____ (attach copy)
- Prescribing/attending physician (last, first name): _____
Phone: () _____ Fax: () _____
- Submitted by (last, first name): _____ From (facility): _____
Phone: () _____ Fax: () _____
Signature: _____ Dated (yyyy/mm/dd): ____/____/____
By signing this, I verify all information in this document to be true and correct.

For AADL Use Only

This is NOT a prescription

Approved for ND O_2 funding (Reference #: _____) Funding Not Approved

Approved for NDS O_2 funding x _____ months (Reference #: _____)

Set-up date (yyyy/mm/dd): ____/____/____ Expiry date (yyyy/mm/dd): ____/____/____

Gap in funding from: _____ to _____ (Exclusive)

For long-term nocturnal O_2 funding request, the following is required:

- 1. Interpreted Full PFT (with BMI)
- 2. Interpreted Level 3 study on room air with CPAP/BPAP
- 3. Compliance of CPAP/BPAP (1-2 page summary from machine download)

Comment: _____

AADL Signature: _____ Dated (yyyy/mm/dd): ____/____/____

The personal information provided on this form is collected under the authority of the Public Health Act (RSA 2000) and the Alberta Aids to Daily Living and Extended Health Benefits Regulation (236/1985) and managed in accordance with the Freedom of Information and Protection of Privacy Act (RSA 2000). The information will be used to determine entitlement to oxygen funding. If you have any questions about the collection of this information, you can contact Disability Supports Division, Health Related Supports, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2. Telephone: 780-427-0731. Fax: 780-422-0968.

How to Complete the Request Form for Short-Term Nocturnal Oxygen Funding for Adults with Sleep Disordered Breathing

This form is for clients (age \geq 18) with sleep disordered breathing who request oxygen with CPAP/BPAP and do NOT qualify for oxygen funding based on resting hypoxemia criteria.

1. Provide client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card.
2. If the client's most recent Level 1 sleep study was not done within the last 3 years, do not submit this request to AADL - a repeat Level 1 sleep study is required.
3. Provide copy of a Level 1 sleep study with histogram, summary and interpretation. Pertaining to the sleep study results and interpretation:
 - a) Apnea Hypopnea Index (AHI) is less than 10 while on CPAP/BPAP
 - b) Raw data showing SpO₂ less than or equal to 85% on room air with CPAP/BPAP
 - c) Evidence of SpO₂ greater than 85% on O₂ with CPAP/BPAPPlease do not submit this request to AADL if any of the above requirements are not met.
4. Provide a copy of the CPAP/BPAP (including O₂) prescription and enter the data of the CPAP/BPAP settings with O₂ flow rate on this request.
5. Provide name, phone and fax numbers of the prescribing or attending physician(s). AADL will fax a copy of the outcome of this request to the specified physician(s).
6. This form has to be reviewed, dated and signed by a RRT or healthcare professional to ensure the information provided in this request is true and correct. Provide printed name, facility and contact information for the RRT or healthcare professional who signed the form.

Submit the completed form and all appropriate test results to **AADL at (780) 638-3254** with all accompanying data for prior approval.

For consideration of long-term nocturnal O₂ funding, AADL may request one or more of the following to be submitted prior to the authorization expiry date:

- a) Interpreted full Pulmonary Function Test (PFT) with body mass index (BMI)
- b) Interpreted Level 3 sleep study on room air with CPAP/BPAP
- c) Compliance of CPAP/BPAP (1-2 page summary from machine download).

Alberta Aids to Daily Living (AADL) Request for Long-Term Nocturnal Oxygen Funding for Adults with Severe Lung Disease and Sleep Disordered Breathing

This form is for clients (age ≥ 18) who request long-term O₂ with CPAP/BPAP and do NOT qualify for O₂ funding based on resting hypoxemia criteria. Clients must already be on short-term nocturnal O₂ funding. Please read the instructions on page 2 prior to completing this form.

- Client's name (last, first): _____
PHN: _____ Date of birth: (yyyy/mm/dd): ____/____/____
- Date of recent interpreted full Pulmonary Function Test (yyyy/mm/dd): ____/____/____ (attach copy)
Severe pulmonary disease (airway obstruction or restriction) Yes No
If "No" to the above question, do not submit this request to AADL as client is not eligible for long-term nocturnal O₂ funding.
- Level 3 study with SpO₂ \leq 85% on room air with CPAP/BPAP Yes No
Date of study (yyyy/mm/dd): ____/____/____ (attach study with interpretation)
If "No" to the above question, do not submit this request to AADL as client is not eligible for long-term nocturnal O₂ funding.
- Compliance of CPAP/BPAP (attach 1-2 page summary, if requested) Yes No
- Prescribed CPAP/BPAP: CPAP _____ cmH₂O IPAP/EPAP _____ Rate _____ O₂ (lpm) _____
- Prescribing physician (last, first name): _____
Phone: () _____ Fax: () _____
- Submitted by (last, first name): _____ From (facility): _____
Phone: () _____ Fax: () _____
Signature: _____ Dated (yyyy/mm/dd): ____/____/____
By signing this, I verify all information in this document to be true and correct.

For AADL Use Only

This is NOT a prescription

Approved for ND O₂ funding (Reference #: _____) Funding Not Approved

Approved for NDS O₂ funding x _____ months (Reference #: _____)

New expiry date (yyyy/mm/dd): ____/____/____ New auth type: _____

Gap in funding from: _____ to _____ (Exclusive)

Comment: _____

AADL Signature: _____ Dated (yyyy/mm/dd): ____/____/____

How to Complete the Request Form for Long-Term Nocturnal Oxygen Funding for Adults with Severe Lung Disease and Sleep Disordered Breathing

This form is for clients (age \geq 18) who request long-term oxygen with CPAP/BPAP and do NOT qualify for oxygen funding based on resting hypoxemia criteria. Clients must already be on short-term nocturnal oxygen funding.

1. Provide client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card.
2. Provide a copy of a recent **interpreted** full Pulmonary Function Test (PFT), completed up to a year before the Long-Term Oxygen application date. The full PFT results and interpretation must show that the client has severe pulmonary disease (airway obstruction or restriction).
Please do not submit this request to AADL if the above requirements are not met.
3. Provide a copy of a recent **interpreted** Level 3 sleep study done on room air with CPAP/BPAP. The results must show SpO₂ less than or equal to 85% for at least 5 continuous minutes.
Please do not submit this request to AADL if the above requirements are not met.
4. If a CPAP/BPAP compliance report is requested by AADL in the previous approval, submit a 1-2 page summary of the machine compliance download. The client is expected to use the CPAP/BPAP nightly with a minimum usage of 4 hours per night.
5. Enter the data of the CPAP/BPAP settings with O₂ flow rate on this request.
6. Provide name, phone and fax numbers of the prescribing or attending physician(s). AADL will fax a copy of the outcome of this request to the specified physician(s).
7. This form has to be reviewed, dated and signed by a RRT or healthcare professional to ensure the information provided in this request is true and correct. Provide printed name, facility and contact information for the RRT or healthcare professional who signed the form.

Submit the completed form and all appropriate test results to **AADL at (780) 638-3254** with all accompanying data for prior approval.

Alberta Aids to Daily Living (AADL) Referral Form to Challenge AADL Walk Test for Clients with Severe Lung Disease

Please read the instructions on page 2 prior to completing this form.

1. Client's Name (Last, First): _____ PHN: _____

2. Diagnosis: _____

3. Date of recent ABG (yyyy/mm/dd): ____/____/____
pH _____, PaCO₂ _____, PaO₂ _____, HCO₃ _____ (or B.E. _____), Sat _____

4. Client is:
- | | | |
|---|------------------------------|-----------------------------|
| a) Ambulatory | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Medically stable | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Physically fit | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Capable of exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) Free of cognitive disabilities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) Willing and able to use portable O ₂ when going out | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g) Desaturates to ≤ 89% (attach hard copy) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "No" to ANY of the above questions, client is NOT eligible to challenge AADL walk test.

5. On CPAP/BPAP Yes No (If on BPAP, client is NOT eligible to challenge AADL walk test)

6. Date of recent full Pulmonary Function Test (yyyy/mm/dd): ____/____/____ (attach hard copy)

BMI _____ (If BMI > 37, client is NOT eligible to challenge AADL walk test)

FEV1 _____ liters _____% pred, FEV1/FVC _____%, DLCO adj _____% pred

TLC _____% pred, VC _____% pred, FRC _____% pred, RV _____% pred

- | | | |
|------------------------------|------------------------------|-----------------------------|
| a) Severe airway obstruction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Restrictive lung disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "No" to BOTH of a) and b) questions, client is NOT eligible to challenge AADL walk test except with documentation of other medical conditions and prior approval from AADL.

Signature: _____ Dated (yyyy/mm/dd): ____/____/____

By signing this, I verify all information in this document to be true and correct.

Print Name (Last, First): _____

Phone: () _____ Fax: () _____

For AADL Use Only

Approved to Challenge AADL Walk Test

Not Approved to Challenge AADL Walk Test

AADL Signature: _____ Dated (yyyy/mm/dd): ____/____/____

How to Complete the Referral Form to Challenge AADL Walk Test for Clients with Severe Lung Disease

This form is to be completed or signed by the Registered Respiratory Therapist, physician or other healthcare professionals.

1. Provide name and personal health number that appear on the Alberta Personal Health card.
2. Include ALL current diagnosis.
3. ABG testing must be done within 3 months from the application date.
4. Client MUST meet ALL the following requirements:
 - a) Ambulatory i.e. client is not in wheelchair, etc.
 - b) Medically stable i.e. client is on an optimal medical treatment with no exacerbation of COPD or hospitalization within the preceding 60 days.
 - c) Physically fit i.e. client walks outside the house regularly 15-20 minutes/day.
 - d) Capable of exercise i.e. client has no angina or cardiac risk or pain related to arthritis or vascular disease, etc.
 - e) Free of cognitive disabilities i.e. can comprehend verbal instruction and would be physically and mentally capable of using exertional oxygen.
 - f) Use portable oxygen when going out i.e. client who refuses to use the oxygen on exertion but will use it post exertion or at night only will NOT be eligible to challenge AADL walk test.
 - g) The prescreen oximetry has to be done within a month from the referral date and the exertion performed has to be on level ground walking. Do not walk up and down the stairs. The exertional oximetry has to show $SpO_2 \leq 89\%$ for at least one continuous minute. Hard copy of the oximetry must be attached with this application, dated and signed by the RRT.
5. If on BPAP, client is NOT eligible to challenge walk test.
6. Full Pulmonary Function Testing (PFT) should be done within a year from the referral date. Hard copy of the full PFT results with interpretation must be attached.
 - If BMI > 37, client is NOT eligible to challenge walk test.
 - If BMI \leq 37 and on CPAP, check for recent PSG.
 - If not done, client is NOT eligible to challenge AADL walk test.
 - If PSG was done, please submit the testing date, the prescribed treatment and client's CPAP compliance report to AADL.
 - If client is non-compliant to the prescribed CPAP treatment, client is NOT eligible to challenge AADL walk test.
 - a) If client meets all the above eligibility criteria and has severe airway obstruction based on full PFT, they may challenge the walk test.
 - b) If client meets all the above eligibility criteria and has restrictive lung disease based on the full PFT, they may challenge the walk test.

If client is eligible to challenge AADL walk test, please fax page one of the completed referral form to **AADL at (780) 638-3254** with all accompanying data.

Eligibility of Alberta Aids to Daily Living (AADL) Walk Test

Client's Name: _____

Client is eligible for this testing if:

1. Arterial blood gas results confirm that the client is not eligible for oxygen at rest;
2. Physician requisition attached; and
3. The Application Form to Challenge AADL Walk Test for Clients with Severe Lung Disease is completed, signed and dated by the client's assessor.

If any of the above conditions are not met, do not proceed with the test as funding will not be provided by AADL.

Evaluation of AADL Walk Test

1. AADL Medical Consultant makes the final decision on the eligibility of oxygen funding.
2. Typically clients may be eligible for exertional oxygen funding if they meet the following criteria:
 - ✓ Desaturate < 80% SpO₂ at any time during the test; or
 - ✓ Show distance walk increases 25% (at least 30 m) on O₂ compared to air; or
 - ✓ Show dyspnea score decreases by 4 Borg points with O₂.

However, individual clients may not qualify for exertional oxygen funding based on review and interpretation by the AADL Medical Consultant.

3. All walk test results must be forwarded to AADL for interpretation. AADL will fax the AADL Walk Test Funding Interpretation form to the testing site and the specialty supplier if applicable.
4. The testing site faxes **ONLY** the AADL Walk Test Funding Interpretation form to the ordering physician. Do **NOT** send the AADL Walk Test Data Report to the physician.

The personal information provided on this form is collected under the authority of the Public Health Act (RSA 2000) and the Alberta Aids to Daily Living and Extended Health Benefits Regulation (236/1985) and managed in accordance with the Freedom of Information and Protection of Privacy Act (RSA 2000). The information will be used to determine entitlement to oxygen funding. If you have any questions about the collection of this information, you can contact Disability Supports Division, Health Related Supports, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2. Telephone: 780-427-0731. Fax: 780-422-0968.

AADL Walk Test Data Report

Background

Client's Name: (Last) _____, (First) _____

Personal Health Number: _____ - _____

Date of Walk Test: (yyyy/mm/dd) _____

Gender: Male Female

Measured Height: _____ (cm/in) Measured Weight: _____ (kg/lb) BMI: _____

Date of Birth: (yyyy/mm/dd) _____ Age: _____

Referring Doctor: General Practitioner Specialist

Is client a smoker?

Yes (___ pack/year) No, quit (___ pack/year) No, never

Recent Arterial Blood Gases (Room Air at Rest)

pH _____ PaCO₂ _____ PaO₂ _____ HCO₃ _____ Sat _____

Date: (yyyy/mm/dd) _____

Recent Room Air Oximetry Results (During Exercise)

Source of Walking Oximetry: Vendor Testing Site Other

Lowest Desaturation: SpO₂ (%) _____ (Attach hard copy)

Date: (yyyy/mm/dd) _____

ALL Current Medications

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Demographics

RRT Tester: (Last) _____ (First) _____

Assistant: (Last) _____ (First) _____

Test Region: (1 to 9) _____ Test Site: _____

Recent Hospitalization Record

Last hospitalization date: (yyyy/mm/dd) _____

Reason for hospitalization _____

Comments _____

Client's Name: _____

Date: _____

1. Initial Rest (6 mins) Flow at 4 liters/min Air or O₂ (circle)

* Dyspnea Score=	* SpO ₂ (%)=	* HR=	*Resp Rate=
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2. Practice Walk (6 mins): 4 liters/min Air or O₂ (circle)

Time (min)	Dyspnea	SpO ₂ (%)	HR	Resp Rate	Comments
1					
2					
3					
4					
5					
6					

* Total distance travelled (meters) = _____

3. Rest on Test Gas (6 mins): 4 liters/min Air or O₂ (circle)

* Dyspnea Score=	* SpO ₂ (%)=	* HR=	*Resp Rate=
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4. Walk on Test Gas (6 mins): 4 liters/min Air or O₂ (circle)

Time (min)	Dyspnea	SpO ₂ (%)	HR	Resp Rate	Comments
1					
2					
3					
4					
5					
6					

* Total distance travelled (meters) = _____

5. Rest on Alternate Gas (6 mins): 4 liters/min Air or O₂ (circle)

* Dyspnea Score=	* SpO ₂ (%)=	* HR=	*Resp Rate=
------------------	-------------------------	-------	-------------

6. Walk on Alternate Gas (6 mins): 4 liters/min Air or O₂ (circle)

Time (min)	Dyspnea	SpO ₂ (%)	HR	Resp Rate	Comments
1					
2					
3					
4					
5					
6					

* Total distance travelled (meters) = _____

7. Rest on Alternate Gas (6 mins): 4 liters/min Air or O₂ (circle)

* Dyspnea Score=	* SpO ₂ (%)=	* HR=	*Resp Rate=
------------------	-------------------------	-------	-------------

*Reading is taken at end of the 6th minute.
Attach hard copy of oximetry from the walk test.

Summary of Results

Client's Name: _____

Test Outcome

1. Did the client desaturate to $SpO_2 < 80\%$? (Yes / No)
2. Is this a complete walk test? (Yes / No)
If answer is no, skip questions 3 and 4.
3. a. Distance walked on air _____ m
b. Distance walked on O_2 _____ m
c. Distance difference _____ m
d. Did the distance walked increase 25% (and at least 30m) on O_2 compared to air? (Yes / No)
4. a. Dyspnea score after walk on air _____
b. Dyspnea score after walk on O_2 _____
c. Did the dyspnea score decrease by 4 Borg points with O_2 ? (Yes / No)

Comments: _____

Discussion of Test with Client

1. Were the test results discussed with the client? (Yes / No)
2. Did the client notice a difference in distance walked or dyspnea score on O_2 ? (Yes / No / NA)
3. Did the client understand the results of the walk test? (Yes / No)
4. Did the client accept the results of the walk test? (Yes / No)
5. Did the client find the test and discussion educational? (Yes / No)

Comments: _____

Evaluation

1. During the test, did the client speculate about the identity of the test gases?
(Yes, go to Q.2 / No, go to Q.3)
2. Were you able to turn the discussion immediately to another topic?
(Yes / No)
3. Are you confident that there was no suggestion, either verbal or non-verbal, about the identity of the test gases which could have been sensed by the client?
(Yes / No)
4. If the client failed to complete the test, what was the reason?

Alberta Aids to Daily Living (AADL) Walk Test Funding Interpretation

The AADL Walk Test was done _____ on _____
(PHN: _____). The Walk Test is to determine eligibility for funding assistance through the AADL Program for home oxygen during exercise. The Walk Test results are summarized briefly below.

Eligible for AADL oxygen funding based on:

1. Desaturation
2. Greater distance walked
3. Decreased dyspnea
4. Desaturation + greater distance walked
5. Desaturation + decreased dyspnea
6. Greater distance walked + decreased dyspnea
7. Desaturation + greater distance walked + decreased dyspnea
8. Medical Consultant approval of incomplete walk test
9. Medical Consultant approval of complete walk test

Comments: _____

Not eligible for AADL oxygen funding based on:

1. Incomplete walk test
2. No significant improvement on distance walked or dyspnea

Comments: _____

If further information is required, please contact AADL Respiratory Unit at (780) 427-0731.

Paul A. Easton
MD, PhD, FRCPC, FACP, FCCP, ABSM
AADL Respiratory Medical Consultant

Dated: ____/____/____
(yyyy/mm/dd)

Alberta Aids to Daily Living (AADL) Prior Approval for Non-Oxygen Funding

Respiratory Specialty Supplier: _____ Region: _____
Submitted By (First Name): _____ Date Submitted: ____/____/____
Client's Name (Last, First): _____ PHN: _____

Request for:

- Non-Portable Suction Model: _____ S/N: _____
- Portable Suction Model: _____ S/N: _____
- Heavy Duty Compressor Model: _____ S/N: _____
- Tracheostomy Tube
- Suction Catheter
- Resuscitator
- Quantity Increase Adding Equipment Deleting Equipment
- Repairing Equipment Labour \$ _____ Parts \$ _____
- Salvaging Equipment
- Other _____

For AADL Use Only

This is NOT a prescription

Auth # for Non- O₂: _____ Start date (yyyy/mm/dd): ____/____/____

- Approved (Reference #: _____) Funding Not Approved

Comment: _____

AADL Signature: _____ Dated (yyyy/mm/dd): ____/____/____

Alberta Aids to Daily Living (AADL) Home Ventilator Client Data Form

This form is to be completed by an AADL consultant for home ventilator start or addition.

- 1 Client Name (Last, First): _____
- 2 PHN: _____ Birthdate (yyyy/mm/dd): ____/____/____
- 3 Address: _____
City: _____ Postal Code: _____
- 4 Phone: (Home) _____ (Work) _____
- 5 Prescribing Physician: _____
- 6 Diagnosis: _____
- 7 Approved Number of Ventilator: One Two Model _____
- 8 Request for Ventilator: Start Set-up Addition
- 9 Date of Discharge: ____/____/____ (_____)
- 10 Ventilator Settings: Mode _____ V_T (ml) _____ Rate _____
Ti (sec) _____ I:E _____ Sensitivity _____
Pressure Support _____ PEEP _____ O₂ (lpm) _____
O₂ Authorization _____ O₂ Vendor _____
- 11 Comment: _____
- 12 Signature of AADL Consultant: _____
- 13 Dated (yyyy/mm/dd): ____/____/____

- | |
|--|
| 14 Date of Start Set-Up/Addition (yyyy/mm/dd): ____/____/____ |
| 15 New/Recycled Ventilator #1: Model _____ Serial Number _____ |
| 16 New/Recycled Ventilator #2: Model _____ Serial Number _____ |

- 17 Authorization # for Ventilator: _____ Q023 (New) Q024 (Recycled)
- 18 Authorization # for Ventilator Set-up, Service, Parts, Labour and Supply: _____
(includes catalogue #: Q021, Q022, Q039, Q040, Q101, Q102, Q103, Q014, Q105 and R846)

Alberta Aids to Daily Living (AADL) Home Ventilator Update Form

This form is to be completed by staff at Respiratory Outreach Program (ROP) when AADL ventilator is returned or exchanged.

1 Client Name (Last, First): _____

2 PHN: _____

3 Reason for the Return of Ventilator(s):

Routine Maintenance

Ventilator Not Working Properly

Client Deceased

Other _____

4 Number of Ventilator Returned: One Two

5 Pick-Up Ventilator #1: Model _____ Serial Number _____

6 Pick-up Ventilator #2: Model _____ Serial Number _____

7 Date of Return (yyyy/mm/dd): ____/____/____

8 Signature of ROP: _____

9 Dated (yyyy/mm/dd): ____/____/____

For Exchange of Ventilator(s):

10 New/Recycled Ventilator #1: Model _____ Serial Number _____

11 New/Recycled Ventilator #2: Model _____ Serial Number _____

Alberta Aids to Daily Living (AADL) Request for Home BPAP Funding for Adults with Neuromuscular, Musculoskeletal or Spinal Cord Disorders

This form is for clients (age ≥ 18) who request ventilatory support for respiratory insufficiency caused by neuromuscular, musculoskeletal or spinal cord disorders. Please read the instructions on page 3 prior to completing this form.

1. Client's Name (Last, First): _____

PHN: _____ Date of birth (yyyy/mm/dd): ____/____/____

2. Current diagnosis: _____

Client has a neuromuscular, musculoskeletal or spinal cord disorder Yes No

If "No" to the above question, do not submit this request to AADL.

3. Date of full PFT (yyyy/mm/dd): ____/____/____ (attach copy)

FEV1 ____ liters (____% pred) FVC ____ liters (____% predicted) FEV1/FVC ratio ____ BMI ____

4. Clients who request BPAP for respiratory insufficiency must meet one of the following:

a) PFT with FVC $\leq 50\%$ predicted Yes No

b) ABG when awake with PaCO₂ ≥ 40 (attach copy) Yes No

c) MIP < 60 cmH₂O Yes No

If "Yes" to ANY of the above questions, go to #5. If "No" to ALL of the above questions, proceed to #6.

5. Pertaining to BPAP titration: Date of study (yyyy/mm/dd): ____/____/____

Location: Hospital Inpatient ICU Sleep Laboratory Monitored In/Out Patient Clinic

ABG before BPAP: pH ____ PaCO₂ ____ PaO₂ ____ HCO₃ ____ (or B.E. ____) Sat ____

ABG after BPAP: pH ____ PaCO₂ ____ PaO₂ ____ HCO₃ ____ (or B.E. ____) Sat ____

Difference of PaCO₂ before and after BPAP > 5 mmHg Yes No

If "Yes" to the above question, client may be eligible for BPAP funding (attach ABG results).

6. Clients who request BPAP for nocturnal respiratory insufficiency alone must meet the following requirement:

PSG shows significant improvement in saturation & TCO₂ after BPAP titration Yes No

If "Yes" to the above question, client may be eligible for BPAP funding (attach PSG summary/report).

If "No" to the above question, do not submit this request to AADL.

7. Prescribed BPAP settings: IPAP/EPAP _____ Rate _____ O₂ (LPM) _____ (attach copy)

8. Prescribing physician (last, first name): _____

Phone: () _____ Fax: () _____

9. Submitted by (last, first name): _____

From (facility): _____

Phone: () _____ Fax: () _____

Signature: _____ Dated (yyyy/mm/dd): _____ / _____ / _____

By signing this, I verify all information in this document to be true and correct.

For AADL Use Only

THIS IS NOT A PRESCRIPTION

Approved for BPAP funding (Reference #: _____) Funding Not Approved

Comment: _____

AADL Signature: _____ Dated (yyyy/mm/dd): _____ / _____ / _____

How to Complete the Request Form for Home BPAP Funding for Adults with Neuromuscular, Musculoskeletal or Spinal Cord Disorders

This form is for clients (age ≥ 18) who request ventilatory support for respiratory insufficiency caused by neuromuscular, musculoskeletal or spinal cord disorders.

1. Provide client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card.
2. Provide current diagnosis. Client must have one of the following diagnoses:
 - a) Progressive neuromuscular disorders, e.g. ALS
 - b) Primary disorders of respiratory muscles, e.g. Muscular Dystrophy
 - c) Chest wall deformities and restrictive disorders of the lung, e.g. Kyphoscoliosis
 - d) Traumatic spinal injuries, e.g. Quadriplegia.
3. Provide a recent interpreted full Pulmonary Function Test (must have been completed a maximum of a year before the BPAP application date). Enter FEV1, FVC actual values in liters and their % predicted, actual ratio of FEV1 to FVC and body mass index (BMI).
4. Client must meet one of the following:
 - a) PFT with FVC ≤ 50% predicted
 - b) ABG when awake with PaCO₂ ≥ 40 (attach copy)
 - c) Maximum Inspiratory Pressure (MIP) < 60 cm H₂OIf "No" to ALL of the above questions, skip to Step #6.
5. Provide BPAP titration study date and location (Hospital Inpatient ICU, Sleep Laboratory or Monitored In/Out Patient Clinic)
Provide ABG data: pH, PaCO₂, PaO₂, HCO₃, or (B.E.) and Sat before and after BPAP
 - If the difference between the PaCO₂ before and after BPAP is greater than 5 mmHg, client is eligible for BPAP funding. Attach ABG records.
6. Client requests for BPAP funding due to nocturnal respiratory insufficiency require: level 1 sleep study histogram, with summary and interpretation showing significant improvement in saturation and TCO₂ after BPAP titration. If this requirement is met, client is eligible for BPAP funding.
7. Provide a copy of the BPAP prescription and enter the data of the BPAP settings (including O₂) on this request.
8. Provide the name, phone and fax numbers of the prescribing and attending physician(s). AADL will fax a copy of the outcome of this request to the specified physician(s).
9. This form has to be reviewed, dated and signed by a RRT or healthcare professional to ensure the information provided in this request is true and correct. Provide printed name and contact information of the RRT or healthcare professional who signed the form.

Submit completed form and all appropriate test results to **AADL at (780) 638-3254** with all accompanying data for prior approval.

Alberta Aids to Daily Living (AADL) Request for Home BPAP Funding for Adults with Sleep Disordered Breathing

This form is for clients (age ≥ 18) who have nocturnal respiratory insufficiency attributed to sleep disordered breathing including sleep apnea, hypoventilation related to obesity or medication. Please read the instructions on page 3 prior to completing this form.

1. Client's Name (Last, First): _____

PHN: _____ Date of birth (yyyy/mm/dd): ____/____/____

2. Current diagnosis: _____

3. Date of full PFT (yyyy/mm/dd): ____/____/____ (attach copy)

FEV1 _____ liters FEV1 _____% predicted FEV1/FVC ratio _____ BMI _____

Has severe airway obstruction (e.g. COPD)? Yes No

If "Yes" to the above question, do not submit this request to AADL. BPAP funding is not usually provided for respiratory insufficiency attributed to severe primary lung disease.

4. Current medication: _____

5. Data pertaining to Level 1 sleep study (attach sleep histogram and interpretation):

Sequence of Events	Date (yyyy/mm/dd)	Min Sat (%)	Average Sat (%)	Max TCO ₂	AHI (per hr)
1) Diagnostic	_____	_____	_____	_____	_____
2) Max CPAP titration	_____	_____	_____	_____	_____
3) BPAP without rate	_____	_____	_____	_____	_____
4) BPAP with rate	_____	_____	_____	_____	_____
5) BPAP with rate & O ₂	_____	_____	_____	_____	_____

a) BPAP funding is usually offered only if CPAP has not resolved respiratory insufficiency.

If CPAP was not attempted or not trialed to ≥ 18 cmH₂O, provide reason: _____

b) If respiratory insufficiency is not resolved with maximum IPAP/EPAP, was rate added?

Yes (maximum rate _____)

No (if rate not attempted, provide rationale: _____)

c) If respiratory insufficiency is not resolved with maximum IPAP/EPAP and rate, was oxygen titrated?

Yes (flowrate added _____ lpm) No

The personal information provided on this form is collected under the authority of the Public Health Act (RSA 2000) and the Alberta Aids to Daily Living and Extended Health Benefits Regulation (236/1985) and managed in accordance with the Freedom of Information and Protection of Privacy Act (RSA 2000). The information will be used to determine entitlement to Home BPAP funding. If you have any questions about the collection of this information, you can contact Disability Supports Division, Health Related Supports, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2. Telephone: 780-427-0731. Fax: 780-422-0968.

6. Client must meet ALL of the following requirements for BPAP funding:

- a) Significant decrease/elimination of respiratory events Yes No
- b) Decrease of peak TCO₂ level Yes No
- c) Improved oxygenation with BPAP Yes No

7. Prescribed BPAP settings: IPAP/EPAP _____ Rate _____ O₂ (LPM) _____ (attach copy)

8. Prescribing physician (last, first name): _____

Phone: () _____ Fax: () _____

9. Submitted by (last, first name): _____

From (facility): _____

Phone: () _____ Fax: () _____

Signature: _____ Dated (yyyy/mm/dd): ____/____/____

By signing this, I verify all information in this document to be true and correct.

For AADL Use Only	THIS IS <u>NOT</u> A PRESCRIPTION
<input type="checkbox"/> Approved for BPAP funding (Reference #: _____)	<input type="checkbox"/> Funding Not Approved
Comment: _____	

AADL Signature: _____	Dated (yyyy/mm/dd): ____/____/____

The personal information provided on this form is collected under the authority of the Public Health Act (RSA 2000) and the Alberta Aids to Daily Living and Extended Health Benefits Regulation (236/1985) and managed in accordance with the Freedom of Information and Protection of Privacy Act (RSA 2000). The information will be used to determine entitlement to Home BPAP funding. If you have any questions about the collection of this information, you can contact Disability Supports Division, Health Related Supports, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2. Telephone: 780-427-0731. Fax: 780-422-0968.

How to Complete the Request Form for Home BPAP Funding for Adults with Sleep Disordered Breathing

This form is for clients (age ≥ 18) who have nocturnal respiratory insufficiency attributed to sleep disordered breathing including: sleep apnea, hypoventilation related to obesity and/or hypoventilation related to medication use.

1. Provide client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card.
2. Provide client's current diagnosis.
3. Provide a copy of a recent interpreted full Pulmonary Function Test which must have been completed within a year before the BPAP application date. 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 lung disease (e.g. COPD), do not submit this request to AADL - BPAP funding is not usually provided to this group of clients.
4. Provide a complete current medication list. If the client has a long list of medications or additional space is required, attach a list.
5. Provide a copy of a Level 1 sleep study histogram, summary and interpretation. Date, Minimum Sat, Average Sat, Maximum TCO₂ and Apnea Hypopnea Index (AHI) per hour must be entered for the events in the following sequence:
 - 1) Diagnostic
 - 2) Max CPAP titration
 - BPAP funding is usually offered only if CPAP has not resolved respiratory insufficiency. If CPAP was not attempted or trialed to ≥ 18 cmH₂O, provide the reason.
 - 3) BPAP without rate
 - When respiratory insufficiency is not resolved with maximum IPAP/EPAP, provide the maximum rate attempted. If a rate was not attempted, provide the reason.
 - 4) BPAP with rate
 - When respiratory insufficiency is not resolved with maximum IPAP/EPAP and rate, provide added oxygen flow rate.
 - 5) BPAP with rate and O₂
6. In order to qualify for BPAP funding, the data entered in #5 must meet all of the following requirements:
 - a) Significant decrease or elimination of respiratory events
 - b) Decrease of peak TCO₂ level
 - c) Improved oxygenation with BPAP
7. Provide a copy of the client's BPAP prescription and enter the data of the BPAP settings (including O₂) on this request.
8. Provide name, phone and fax numbers of the prescribing and attending physician(s). AADL will fax a copy of the outcome of this request to the specified physician(s).
9. This form has to be reviewed, dated and signed by a RRT or healthcare professional to ensure the information provided in this request is true and correct. Provide printed name, facility and contact information for the RRT or healthcare professional who signed the form.

Submit the completed form and all appropriate test results to **AADL at (780) 638-3254** with all accompanying data for prior approval.

Alberta Aids to Daily Living (AADL) Home BPAP Client Data Form

- 1 Client Name (Last, First): _____
- 2 PHN: _____ Birthdate (yyyy/mm/dd): ____/____/____
- 3 Address: _____
City: _____ Postal Code: _____
- 4 Phone: (Home) _____ (Work) _____
- 5 Prescribing Physician: _____
- 6 Diagnosis: _____
- 7 100% AADL Cost Share Cost Share Exempt (reached \$500 for this benefit year)
- 8 Request for BPAP: Start Exchange Exchange (Under Warranty) Return (UAH C.E.)
Reason for Exchange/Return: _____
- 9 Approved BPAP: New Recycled With Rate (Q300) Without Rate (Q301)
- 10 Name of Service Provider: _____ Branch: _____
- 11 Comment: _____
- 12 BPAP Settings: IPAP _____ EPAP _____ Rate _____ O₂ _____ LPM
- 13 Signature of AADL Consultant: _____
- 14 Dated (yyyy/mm/dd): ____/____/____

- 15 Date of Start Set-Up/Exchange/Exchange Under Warranty/Return (yyyy/mm/dd): ____/____/____
- 16 New/Recycled BPAP Model: _____ Serial No: _____

- 17 Authorization # for New Machine: _____ Q300 Q301
- 18 Authorization # for Start Set-Up: _____ Q312 Q311 Z312 Z311
- 19 Authorization # for Shipping: _____ Z330 Z331
- 20 Authorization # for Supplies: _____ Q038
- 21 Authorization # for Repair: _____ Q031 Q032
- 22 Non-Functioning/Returned BPAP: Model _____ Serial No. _____

Government of Alberta ■

Disability Supports Division
Health Related Supports
10th Floor Milner Building
10040 – 104 Street NW
Edmonton, Alberta T5J 0Z2
Canada
Telephone: 780-427-0731
www.seniors.alberta.ca/aadl

Alberta Aids to Daily Living (AADL) Prior Approval for BPAP Supplies

Client's Name (Last, First): _____

PHN: _____

Authorization # for BPAP Supplies: _____ Catalogue #: Q038

100% AADL Cost Share Cost Share Exempt (reached \$500 for this benefit year)

Description	Part #	Qty	Price
Total			

Specialty Supplier: _____ Branch: _____

Tel: () _____ Fax: () _____

Submitted by (Last, First): _____

Date Submitted (yyyy/mm/dd): _____/_____/_____

Funding Approved Funding Not Approved

Comment: _____

AADL Signature: _____

Dated (yyyy/mm/dd): _____/_____/_____

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