SOCIAL DEVELOPMENT
Health Services Program
P.O. Box 5500, Frederiction, N.B., E3B 5G4
Toll Free: 1-844-551-3015
Fax: (506) 444-4611

New Nouveau Brunswick CANADA

DÉVELOPPEMENT SOCIAL
Programme des Services de santé
C.P. 5500, Fredericton N.-B., E3B 5G4
Sans Frais: 1-844-551-3015
Télécopieur: (506) 444-4611

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 SPECIALIST CONTACT INFORMATION

NAME : ____________________

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		Description
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.

PLEASE ADVISE HEALTH SERVICES OF ANY CHANGES

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		
Mechanical Insuffulator-Exsufflator (Cough Assist Machine)	☐	$	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	$		**Total**	$

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**	$			

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 : ____________________ Date : ____________________

FOR OFFICE USE ONLY (Social Development)

APPROVED	☐	REFUSED	☐	PENDING INFO	☐

APPROVAL NUMBER TRIAL ☐ RENTAL ☐ PURCHASE ☐

Administrator
Administrateur ____________________ Date : ____________________

Comments :

REGISTERED

June 2024