Positive Airway Pressure Machine Assessment Form

INSTRUCTIONS:

1. Have your physician complete this form.
2. Attach the form and all receipts/estimate to your claim form. Retain copies of all documents for your records.
3. Submit your claim to the Benefit Payment Office indicated on your claim form.
4. **For Residents of Saskatchewan, Manitoba and Ontario:** You must apply for coverage through the appropriate Provincial Health Program before submitting a claim or estimate to Canada Life.

Patient Name:	Date of Referral:

1. **Is this an initial machine?** ☐ Initial **(please go to Section 1)**
2. **If this is a replacement machine, please answer a, b, c and d below.**
   a. What was the patient's previous device? ☐ CPAP ☐ APAP ☐ BPAP ☐ VPAP ☐ ASV (Adaptive Servo Ventilation)
   b. When did the patient get their previous device? _____ (mm) / _____ (yyyy)
   c. What is the patient's new device? ☐ CPAP ☐ APAP ☐ BPAP ☐ VPAP ☐ ASV (Adaptive Servo Ventilation)
   d. Please advise why the patient needs a new machine or why they are getting a different type of machine (i.e., a BPAP instead of a CPAP)

_____

_____

Section 1: Request for Initial PAP device (all types)

1. **What type of device are you prescribing your patient?** ☐ CPAP ☐ APAP ☐ BPAP ☐ VPAP ☐ ASV
2. **What type of Sleep Study did the patient participate in?**
   ☐ Level 1 (lab/clinic) ☐ Level 3 (home study) ☐ Other: _____ (please specify)
   ***** Please attach a copy of Sleep Study diagnostic report and any titration**
3. **Which diagnosis does the Sleep Study confirm? (check one)**
   ☐ Mild OSA ☐ Mod/Severe OSA ☐ Other: _____ (please specify)
4. For mild OSA, please advise if patient:
   ☐ has other medical conditions/comorbidities. Please specify: _____
   ☐ works in a "safety-sensitive" profession/occupation? Please specify: _____

Section 2: Request for initial BPAP/VPAP/ASV device only (**please provide medical information and test results to support the checked items)

Please check all that apply and provide medical information and test results to support the checked items:

☐ Nocturnal O2 saturation <88% on CPAP of 15 cm H2O or greater
☐ Nocturnal hypercapnea on CPAP 15 cm H2O or greater
☐ Apnea/hypopnea index of > 10 on CPAP 15 cm H2O or greater
☐ Obesity hypoventilation syndrome
☐ Opioid induced sleep disordered breathing
☐ Cheyne-stokes respirations
☐ Requires pressures of ≥ 15 cm H2O
☐ Unable to tolerate any level of CPAP despite adequate trial
☐ Remains symptomatic despite adequate CPAP trial (Epworth score: _____)
☐ Chronic hypercapnic respiratory failure
☐ Central/mixed sleep apnea
☐ Neuromuscular disease or chest wall disease affecting respiration. Please specify: _____
☐ Other, please specify: _____

Form completed by:

☐ I certify that the information provided is true, correct, and complete.

_____

Referring Physician's name, registration number and designation (please print)

_____ _____

Physician's signature Telephone number:

Questions? Call Toll Free 1.800.957.9777
www.canadalife.com

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