

**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:
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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:

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