

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: _____