BCITS technology for living
Provincial Respiratory Outreach Program ▪ PROP
Technology for Independent Living Program ▪ TIL

PROVINCIAL RESPIRATORY OUTREACH PROGRAM

PRESCRIPTION FOR SERVICES

PLEASE FAX TO: 604-326-0176 **QUESTIONS: 1-866-326-1245**

CLIENT INFORMATION:

FIRST NAME:	LAST NAME:	
DATE OF BIRTH:	PHONE NUMBER:	
ADDRESS:		FACILITY: ☐ YES ☐ NO
		POSTAL CODE:
FUNDING AGENCY (IF APPLICABLE)		BC RESIDENT: ☐ YES ☐ NO

CLINICAL ASSESSMENT:

CLINICAL ASSESSMENT ATTACHED (INCLUDE REASONING FOR HOME VENTILATION): ☐

DIAGNOSIS:			
SECONDARY DIAGNOSIS:			
MEDICAL HISTORY:			
VITAL CAPACITY (L. and % pred) :	Date:	ABG'S	Date:

EQUIPMENT REQUIREMENTS

☐ BILEVEL: ∗ *Please note IPAP and EPAP parameters must be filled in.*

SPONTANEOUS: YES ☐ NO ☐		SPONTANEOUS/TIMED: YES ☐ NO ☐
IPAP: **Min**: ________ **Max**: ________ cm/H_2O	EPAP: **Min**: _______ **Max**: _______ cm/H_2O	RESPIRATORY RATE:
INTERFACE: MAKE & SIZE:		
SUPP. O_2 :	HAVE ARRANGEMENTS BEEN MADE WITH OXYGEN SUPPLIER? YES ☐ NO ☐	

☐ VOLUME VENTILATOR:

MODE:	VOLUME:	I:E / % /Ti	
RESPIRATORY RATE:	PRESSURE:	VENT ALARM:	WAVE FORM:
LOW PRESSURE:	HIGH PRESSSURE:	SENSITIVITY B/E:	PRESSURE CONTROL:
TRACHEOSTOMY TUBE: MAKE & SIZE:			
CUFFED: ☐ CUFFLESS: ☐	FENESTRATED: YES ☐ NO ☐	OTHER:	
SUPP. O_2 :	HAVE ARRANGEMENTS BEEN MADE WITH OXYGEN SUPPLIER? YES ☐ NO ☐		

I authorize the addition of the following treatment modalities as required:

☐ ORAL SUCTION DEVICE ☐ MANUAL COUGH ASSIST ☐ AEROSOL COMPRESSOR

∗ AUTHORIZATION/MANDATORY INFORMATION

NAME OF RESPIROLOGIST:	CLIENT ABLE TO DIRECT CARE: ☐ YES ☐ NO
PHONE NUMBER:	FAX NUMBER:
RESPIROLOGIST'S SIGNATURE:	DATE:

PROVINCIAL RESPIRATORY OUTREACH PROGRAM

MANDATORY CLIENT INFORMATION AND RELEASE FORM (PLEASE PRINT)

PERSONAL INFORMATION

Name of Applicant:____

(First) (Last)

Date of Birth:____________________ Sex: M: ☐ F: ☐ Date of Application:____________________

M/D/Y M/D/Y

Name of Current Care Residence (if applicable):______________________________

Street Address:____

City:______________________________Postal Code:____________________

Phone: ____________________(ext)__________Fax:____________________Email:____________________

Home Address if different from above:

Street Address: ____

City:______________________________Postal Code:____________________

Phone:____________________(ext)__________Fax:____________________ Email:____________________

CONTACT PERSONS

(i.e., A person who will assume responsibility for completion of forms, arranging appointments, etc. if client is unable to do this.)

Primary Contact:

Name:______________________________Relationship to client:____________________

Street Address:____

City:______________________________Postal Code:____________________

Phone:____________________(ext)__________Fax:____________________Email:____________________

Alternate Contact:

Name:______________________________ Relationship to client: ________________

Street Address:____

City:______________________________ Postal Code: ________________

Phone:____________ (ext)________ Fax:______________ Email: ________________

Form Completed by:

Client: Yes ☐ No ☐ Primary Contact: Yes ☐ No ☐ Alternate Contact: Yes ☐ No ☐

If none of the above:

Name: ______________________________ Relationship to client: ________________

Street Address: ____

City: ______________________________ Postal Code: ________________

Phone: ____________ (ext)________ Fax:______________ Email:______________

PHYSICIAN INFORMATION

Referring Respirologist/Physician: ______________________________________

Phone:____________ (ext)________ Fax: ______________________________

Facility: ______________ Phone:______________ (ext) Fax:______________

Address:____

______________________________ Postal Code: ______________________

Family Physician: ____

Phone: ______________________ (ext)____ Fax: ______________________

Address: ____

____

BCITS technology for living

1PROVINCIAL RESPIRATORY OUTREACH PROGRAM
AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION

The BC Association for Individualized Technology and Supports for People with Disabilities (BCITS) works co-operatively with other agencies on behalf of the client and in the best interest of the client. In order to work effectively with these agencies, the BCITS representative will on occasion need to correspond, either in written or verbal form, with that agency only as it relates to the individuals' respiratory care.

I,__________________________, hereby authorize the BCITS and/or its representatives to release or obtain from such agencies, individuals, medical centres or hospitals as are concerned with my care, any and all pertinent information which may be necessary to assist in providing me with respiratory related services.

I also consent to:

- ☐ Visits by a BCITS representative (ie. Respiratory Therapist)
- ☐ A BCITS representative attending meetings, specifically regarding my care and/ or discharge planning
- ☐ A BCITS representative acting as a community resource
- ☐ Would like to be contacted by Peer Support Group
- ☐ Would not like to be contacted by Peer Support Group

I have been informed of all the reasonably foreseeable disclosures of information, including to third party payers such as insurance companies, and understand and agree that these disclosures are made by BCITS with my permission. When such disclosures are in writing, I will be sent a copy. This release is in effect only as long as my file remains open and active with the BCITS.

Any personal information received by The BC Association for Individualized Technology and Supports for People with Disabilities is protected under the BCITS Personal and Business Conduct Policy (1996) and the Freedom of Information and Protection Privacy Act.

SIGNATURE: ___________________________________ DATED THIS ________ DAY OF _______________ 20____

CLIENT FIRST NAME:______________________________ LAST NAME: _________________________________

THE FOLLOWING TO BE COMPLETED BY WITNESS IF ABOVE SIGNED WITH AN "X" OR BY CLIENT REPRESENTATIVE IF CONSENT IS MADE ON CLIENT'S BEHALF:

FIRST NAME:______________________ LAST NAME: _____________________________ PHONE : ______________

SIGNATURE: _____________________________ RELATIONSHIP TO CLIENT: _______________DATE:___________