Ontario

**Ministry of Health**

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# Addendum for Ventilator Equipment and Supplies Application Form

**To be completed by the prescribing physician to facilitate processing a request for Ventilator Equipment and Supplies.**

## Section 1 – Applicant's Information

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Health Card Number (10 digits) | Version |
|---|---|
| | |

## Section 2 – Diagnosis: physician to indicate primary and secondary diagnosis

☐**Neuromuscular Disorders**

☐Amyotrophic lateral sclerosis ☐Muscular Dystrophy (specify)

☐Diaphragm paralysis ☐Spinal Cord Injury ☐SMA

☐**Chest Wall Deformities**

☐Kyphoscoliosis ☐Other (specify)

☐**Central Respiratory Drive Depression**

☐Drugs - (e.g. Narcotics) ☐Neurological disorders (e.g. Trauma, stroke, multiple sclerosis)

☐**Obesity Hypoventilation Syndrome**

☐**Obstructive Sleep Apnea Syndrome (OSAS)**

☐Complicated OSAS ☐CPAP intolerant ☐CPAP-emergent Central apnea

☐**Chronic Obstructive Pulmonary Disease (COPD)**

☐**Other** (specify)

## Section 3 – Equipment Details

**Ventilator**

| Ventilator | Quantity ☐1 ☐2 |
|---|---|
| | |

| Circuit Type | Ventilator Settings |
|---|---|
| | |

Ventilator Interface ☐Mask ☐Mouthpiece ☐Tracheostomy

**Bi-Level ST**

| Inspiratory Time (Ti) | IP | EP | Rate | Humidifier ☐Yes ☐No | Quantity ☐1 ☐2 |
|---|---|---|---|---|---|
| | | | | | |

Hours of Ventilation/Ventilation Assist ☐< 12 ☐12-24 ☐24

| Battery ☐Yes ☐No | Charger ☐Yes ☐No | Cable ☐Yes ☐No |
|---|---|---|
| | | |

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| Applicant's Last Name | First Name | Health Number (10 digits) | Version |
|---|---|---|---|
| | | | |

**Mechanical In-Exsufflation**

Settings

| Insp. Pressure | Exp. Pressure |
|---|---|
| | |

**Saturation Monitor** (max of 2 years)

| Start Date (yyyy/mm/dd) | End Date (yyyy/mm/dd) |
|---|---|
| | |

Alarm Setting

| High Sp02 | Low Sp02 |
|---|---|
| | |
| High HR | Low HR |
| | |

## Section 4 – Equipment Delivery Instructions

Deliver to

☐Client's Home

**Client's Home Address**

| Unit Number | Street Number | Street Name | | |
|---|---|---|---|---|
| | | | | |
| Lot/Concession/Rural Route | | City/Town | Province | Postal Code |
| | | | | |
| Telephone Number | | | | |
| | | | | |

☐Facility

**Facility Address**

Facility Name

| Unit Number | Street Number | Street Name | | |
|---|---|---|---|---|
| | | | | |
| Lot/Concession/Rural Route | | City/Town | Province | Postal Code |
| | | | | |

**Facility Contact Person**

| Last Name | First Name | |
|---|---|---|
| | | |
| Floor Number | Room Number | Telephone Number ext. |
| | | |
| Email Address | | |
| | | |

**Physician Signature**

| Physician Last Name | Physician First Name |
|---|---|
| | |
| Physician Signature | Date Signed (yyyy/mm/dd) |
| | |