Ontario

Ministry of Health

PAP Device Evaluation Form

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Section 1 – ADP Registered Sleep Clinic Information

Clinic Name	Clinic Number

Contact Person

Business Telephone Number ext.	Email Address

Section 2 – Evaluator Information

Start Date of Product Evaluation (yyyy/mm/dd)	End Date of Product Evaluation (yyyy/mm/dd)
Evaluator Name	Professional Title
Evaluator Name	Professional Title

Section 3 – Positive Airway Pressure Device Information

Manufacturer	Description of Device (Make and Model)
Manufacturer Contact Person	Business Telephone Number ext.

Section 4 – Evaluation: Clinical Assessment

Please answer the following questions

Describe the protocol used to clinically evaluate the equipment

Identify the conditions which would require the use of this device

Describe the effectiveness of this device in treating the conditions listed above

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Comments or recommendations to the manufacturer

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Section 5 – Evaluation: Performance/Safety

Is the on/off selection switch easily accessible to the user?

☐ Yes ☐ No

If no, please explain

Is the pressure selection switch (if applicable) easily accessible to the user?

☐ Yes ☐ No

If yes, how does the manufacturer address this issue?

Are there any sharp edges/protrusions?

☐ Yes ☐ No

If yes, please explain

Are valves (if applicable) designed to be assembled in one manner only?

☐ Yes ☐ No

If no, please explain

Is the pressure range acceptable?

☐ Yes ☐ No

If no, please explain

Does the device deliver the specified pressure and flow?

☐ Yes ☐ No

If no, please explain

Comments and recommendations to the Manufacturer

Section 6 – Evaluation: Durability/Reliability

CPAP/APAP/BPAP Pressure Blower

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Nasal Mask

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Headgear

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Corrugated Tubing

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Pressure/Non-rebreathing

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Pressure Adapters/Oxygen Entrainment

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Other

Rate the client response to this device using the following scale:
1 (poor) to 10 (excellent)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

If any response was scored below 5, please explain

Did anything break or malfunction during the evaluation period?

☐ Yes ☐ No

If yes, please specify what failed and the circumstances in which the failure occurred

Comments and recommendations to the Manufacturer

Section 7 – Conclusion

The device would meet the needs of your patients.

☐ Yes ☐ No

Does this unit compare in cost to existing technology?

☐ Yes ☐ No

Comments

Identify advances in technology present in this device

Describe the advantages as they relate to the patient/client

Equivalent Purpose Devices

Name of equivalent	Price of equivalent (if available)

Evaluator Information

Name of evaluator	Title

Signature	Date (yyyy/mm/dd)

This form is intended to identify potential products for ADP funding. It does not constitute an endorsement of the product.
Please return the completed form to: Assistive Devices Program, 5700 Yonge St., 7th Floor, Toronto ON M2M 4K5.
Attention: Program Coordinator, Respiratory Devices.