

**PLEASE FAX TO: 604-326-0176**

**CLIENT INFORMATION:**

FIRST NAME:		LAST NAME:	
DATE OF BIRTH:		PHONE NUMBER:	
ADDRESS:		FACILITY: <input type="checkbox"/> YES <input type="checkbox"/> NO	
		POSTAL CODE:	
FUNDING AGENCY (IF APPLICABLE)		BC RESIDENT: <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/>		SPONTANEOUS/TIMED: YES <input type="checkbox"/> NO <input type="checkbox"/>	
IPAP: <b>Min:</b> _____ <b>Max:</b> _____ cm/H <sub>2</sub> O	EPAP: <b>Min:</b> _____ <b>Max:</b> _____ cm/H <sub>2</sub> O	RESPIRATORY RATE:	
INTERFACE: MAKE & SIZE:			
SUPP. O <sub>2</sub> :	HAVE ARRANGEMENTS BEEN MADE WITH OXYGEN SUPPLIER? YES <input type="checkbox"/> NO <input type="checkbox"/>		

**VOLUME VENTILATOR:**

MODE:	VOLUME:	I:E / % /Ti	
RESPIRATORY RATE:	PRESSURE:	VENT ALARM:	WAVE FORM:
LOW PRESSURE:	HIGH PRESSURE:	SENSITIVITY B/E:	PRESSURE CONTROL:
TRACHEOSTOMY TUBE: MAKE & SIZE:			
CUFFED: <input type="checkbox"/> CUFFLESS: <input type="checkbox"/> FENESTRATED: YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER:			
SUPP. O <sub>2</sub> :	HAVE ARRANGEMENTS BEEN MADE WITH OXYGEN SUPPLIER? YES <input type="checkbox"/> NO <input type="checkbox"/>		

**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: <input type="checkbox"/> YES <input type="checkbox"/> 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: \_\_\_\_\_ M/D/Y Gender: M: [ ] F: [ ] Date of Application: \_\_\_\_\_ 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: \_\_\_\_\_

\_\_\_\_\_



**PROVINCIAL RESPIRATORY OUTREACH PROGRAM  
AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION**

Technology For Living 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 Technology For Living 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 Technology For Living 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 Technology For Living representative (ie. Respiratory Therapist)
- A Technology For Living representative attending meetings, specifically regarding my care and/ or discharge planning
- A Technology For Living 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 Technology For Living 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 Technology For Living.

Any personal information received by The Technology For Living is protected under the 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: \_\_\_\_\_