

## RX FOR PROP SERVICES

### CLIENT INFORMATION:

FIRST NAME:	LAST NAME:		
DATE OF BIRTH:	PHONE NUMBER:		
ADDRESS:		APPLICANT TO RESIDE IN FACILITY? IF YES, SEE REVERSE FOR NON-MEDICAL CRITERIA	
		PHN:	
		POSTAL CODE:	
WORKSAFE/ICBC FILE? <input type="checkbox"/> YES <input type="checkbox"/> NO		BC RESIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO	

### CLINICAL ASSESSMENT:

CLINICAL ASSESSMENT ATTACHED (INCLUDE RATIONALE 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.

MODE:			
IPAP: Min: _____ Max: _____ cm/H <sub>2</sub> O	EPAP: Min: _____ Max: _____ cm/H <sub>2</sub> O	RESPIRATORY RATE:	
MASK INTERFACE: MAKE & SIZE:			
SUPPLEMENTAL OXYGEN? YES <input type="checkbox"/> NO <input type="checkbox"/> I/MIN _____			
HOP APPLICATION SUBMITTED? YES <input type="checkbox"/> NO <input type="checkbox"/>			

**VOLUME VENTILATOR:**

MODE: PC _____ AC _____	VOLUME:	PRESSURE:	RR:
ADDITIONAL INFORMATION:			
TRACHEOSTOMY TUBE <input type="checkbox"/>			
MAKE & SIZE:		ADDITIONAL INFORMATION:	
SUPPLEMENTAL OXYGEN? YES <input type="checkbox"/> NO <input type="checkbox"/> I/MIN _____			
HOP APPLICATION SUBMITTED? YES <input type="checkbox"/> NO <input type="checkbox"/>			

**ORAL SUCTION DEVICE**

**MANUAL COUGH ASSIST**

**AEROSOL COMPRESSOR**

### \* AUTHORIZATION/MANDATORY INFORMATION

NAME OF RESPIROLOGIST:		APPLICANT ABLE TO DIRECT OWN CARE? SEE REVERSE FOR ADDITIONAL INFORMATION	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHONE NUMBER:		FAX NUMBER:	
RESPIROLOGIST'S SIGNATURE:		DATE:	

## **PROP Medical Criteria**

Individuals who meet the following medical criteria may be eligible for PROP services:

- Candidates should be stable and optimally managed for any reversible component of their associated pulmonary disease.
- Candidates are required to be under the care of a Respiriologist on discharge
- Individuals with neuromuscular disorders or chest wall restrictions that have documented hypercapnia (PCO<sub>2</sub> at rest on room air >45mmHg).
- Individuals who have neuromuscular disorders or chest wall restrictions that have normal PaCO<sub>2</sub>'s (in the range of 40-45 mmHg) may be considered eligible if any of the following other criteria are present:
  - I. Cor Pulmonale
  - II. Nocturnal hypoventilation (as documented by elevation in nocturnal CO<sub>2</sub> (TCCO<sub>2</sub>) levels and associated morning symptoms)
  - III. Severe supine dyspnea i.e., Diaphragmatic paralysis
  - IV. Symptoms of alveolar hypoventilation
- Individuals with normal neuromuscular function but who have documented central alveolar hypoventilation secondary to abnormal ventilatory control may qualify i.e., Primary Alveolar Hypoventilation or Obesity Hypoventilation Syndrome
- Individuals who use a tracheostomy with re-usable (whenever possible) inner cannula. Uncuffed tracheostomy tubes are preferred; potential members requiring a cuffed tracheostomy tube will be assessed for program eligibility on an individual basis. Speaking valves used with uncuffed tracheostomy tubes will be considered when they are situated in-line with documented evidence of being well tolerated and within accepted risk parameters.
- Individuals who are not PEEP dependent
- Individuals whose secretions can be safely managed without the use of in-line suction.

## **PROP Non-Medical Criteria**

- Must be 19 years of age or older
- Must be a BC citizen and registered with the BC Medical Services Plan
- Candidates must be capable of self-directing their therapy so that they have control over their choices and decisions when it comes to their own respiratory care and therapy or have a current and appropriate Representation Agreement in place.
- Candidates who reside in assisted living/transitional care facilities are eligible if they can direct their own respiratory care and therapy (via themselves or through a Representation Agreement) and no other service provider (other than their physician/Respiriologist) is involved in directing PROP clinicians in care.
- Candidates are strongly encouraged to have a current Representation Agreement in place prior to application being made.

## **At Home Program Applicants:**

- All candidates coming from the At Home Program are required to have made formal application to PROP through a prescription for services
- It is recognized that candidates coming from the At Home Program are sometimes not able to fully participate themselves in decisions about their respiratory care and therapy and that a parent or other designated representative will be involved; in this situation, a current Representation Agreement must be in place.