Setup Checklist

Client Name:_____ Date of Setup:_____

Machine chosen: _____ S/N: _____

Interface (mask) chosen: _____

Therapeutic Information Checklist

Obstructive Sleep Apnea Syndrome (OSAS) reviewed. ☑
Requirement for CPAP/BIPAP therapy explained. ☑
Benefits and risk factors associated with CPAP/BIPAP explained. ☑
Client's CPAP/BIPAP prescription verified (cm H20). ☑

Equipment Checklist

Client shown a wide selection of CPAP/BIPAP interfaces (masks) and machines ☑
at time of setup or purchase of equipment. ☑
Client's mask fitted for comfort and leaks in various sleeping position. ☑
Safe and proper management of CPAP/BIPAP equipment explained. ☑
Equipment cleaning procedure, and maintenance explained. ☑
Equipment warranty reviewed: **Machine warranty_____years**
Interface warranty_____months
CPAP/BIPAP machine set to prescribed pressure of _____cm H20

Funding Checklist

Assistive Devices Program (ADP) coverage explained. ☑
Coverage from ODSP, Ontario Works, and Third Party Insurance Explained. ☑
ADP form signed by the client. ☑
Health Card number verified. ☑
Release of Information form signed and witnessed. ☑

Rx Pressure (cmH20): _____
Pressure Setting: _____
Replacement Unit: _____ Model#: _____
S/N: _____ Part# (if applicable): _____

Comments: _____
_____

Client Signature: _____ Date (d.m.y): _____

Witness Signature: _____ Date (d.m.y): _____

All Medical Equipment Sales Are Final

Consent to Treatment and Financial Responsibility

I,_____ understand:

• my need for positive airway pressure (PAP)/adaptive servo-ventilation therapy as well as its benefits;

• the risks factors associated with the treatment of my obstructive sleep apnea;

• how to safely and properly use and maintain all of the equipment provided to me by CPAP Direct Ltd., and will care for it according to the instructions that I have received;

• that I am financially responsible for all of the equipment provided to me;

• that I am responsible for verifying my own eligibility for health insurance coverage and filing my own health insurance claim, and acknowledge that CPAP Direct Ltd. will in no way be responsible for collecting for my insurance claim or for negotiating a settlement on a disputed claim on my behalf; and

• that if either the Ontario Ministry of Health(Assistive Devices Program) or my insurance company fail to remit any of the amount for which it has been credited at the time of purchase, for any reason, I am responsible for the full remaining balance

Client Signature_____ Date(d.m.y)_____

Witness Signature_____ Date(d.m.y)_____

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize **CPAP DIRECT LTD.**
(Print your name) *(Print name of health information custodian)*

to disclose

my personal health information consisting of:

my private medical information in relation to facilitating the sleep test, providing treatment to my sleep disorder (Sleep Apnea) and managing the ongoing follow-ups of the sleep disorder (Sleep Apnea).

_____
(Describe the personal health information to be disclosed)

or

the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of:_____

_____
(Describe the personal health information to be disclosed)

to _____
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:_____ **Address:** _____

Home Tel: _____ _____

_____

Work Tel: _____

Signature:_____ **Date:**_____

Witness Name:_____ **Address:** _____

Home Tel: _____ _____

_____

Work Tel: _____

Signature:_____ **Date:**_____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**