

HOME OXYGEN PROGRAM APPLICATION

www.vch.ca/programs/hop.htm

Please complete in FULL and PRINT CLEARLY. See reverse side for Terms. Subsidy may be refused or delayed if application is incomplete, illegible or unsigned by physician

	1. DATE of API	PLICATION			<u>. </u>				
	☐ New Applicate	ion Date:	mm / dd / yyyy	Hospital Disc	al Discharge Date (if applicable):				
		CLIENT DATA							
	Sumame:		First Name: _		Middle Name:				
	D.O.B	mm / dd / yyyy	Male Female PHN:						
		itreet Address: City							
	Mailing Address:	Mailing Address:				Postal Code			
ļ	Home Phone:	Home Phone: Work Phone:			Cell:				
l	Contact / Next of	Contact / Next of Kin:				Relationship:Phone:			
l	Third Party Coverage / Extended Health Benefits: (specify): VAC, NIHB, Pacific Blue Cross, Sun Life, Clarica, Other:								
	3. CLINICAL IN	IFORMATION	Note: Palliative clier	its must have doc	imented hypoxemia				
	Primary Dx: Secondary Dx:								
	☐ Clinically Significant CHF ☐ Cor Pulmonale ☐ Pulmonary Hypertension ☐ Polycythemia ☐ Obstructive Sleep Apnea ☐ Smoker								
4. DIAGNOSTIC DATA Data must be obtained <96 hours prior to application and/or discharge date									
- 	Test	Date	O₂ Flow Rate	O ₂ Saturation	pН	Pa CO₂	PaO₂	HCO₃	
-	<u> </u>								
D Boom Alt Outmate Study Attached To Analysis Color 1975									
	Room Air Oximetry Study Attached Ambulatory Oximetry Study Attached Nocturnal Oximetry Study Attached Additional Information:								
	roundia mornaton.								
	5 DEEEDDAI	INFORMATION	N.						
1	5. REFERRAL INFORMATION								
	Referring Physician:				Referred by: MD/ NP Office Hosp Ward Ward Ward				
	Doctor Number:				☐ Other Completed by: Phone:				
		Fa		Hos	Hospitals: Use VitalAire only. Phone for all After Hours, Weekend, Statutory				
	Family Physician:				Holiday and Urgent Discharges. Dr / NP Office/ Other: Fax HOP at 604-301-3829 / (Ph): 604-301-3814				
	Other MD incl Nurse	Practitioner:			Approved Suppliers: VitalAire (Ph): 1-800-637-0202 / (Fax): 1-866-812-0202				
MedPro Respiratory (Ph): 1-888-310-1444 / (Fax): 1-888-								-1441	
ı	6. PRESCRIPTION At RestIpm On AmbulationIpm NocturnalIpm MD/ NP SIGNATURE: (mandatory) DATE:								
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- 1									
L	MD/ NP: By signing above you are authorizing a prescription for oxygen and ongoing titration of flow rate by HOP and Oxygen Supplier Respiratory Therapist to maintain SpO2 ≥ 90% at rest, on exertion, and nocturnally; and are accepting the Program's 'Terms' on the reverse on behalf of this client. Oxygen equipment will be determined by HOP.								
No.	7. HOP SUBSI	DY REVIEW F	or HOP use only						
		APPROVED	REJECTED	Co	mments:				
							R	evised June 2008	