



The personal information collected on this form will be used for the purpose of providing At Home Program benefits and will be treated confidentially in compliance with the Freedom of Information and Protection of Privacy Act.

This request is for: [ ] At Home Medical Benefits Program [ ] Medical Benefits for Children in Care Program

SECTION 1 CHILD INFORMATION

Form with fields: NAME OF CHILD, DATE OF BIRTH (YYYY/MM/DD), PHONE NUMBER ( ), ADDRESS, CITY/TOWN, POSTAL CODE

Form with field: PRIMARY DIAGNOSIS

Form with fields: DATE OF REQUEST(YYYY/MM/DD), DATE OXIMETER IS REQUIRED (YYYY/MM/DD), APPROXIMATE LENGTH OF TIME OXIMETER WILL BE REQUIRED

SECTION 2 CLINICAL JUSTIFICATION

Please check the appropriate box to indicate which of the following categories best describes the child's need for an oximeter:

- 1. Infant, child or youth with a compromised airway who meets at least one of the following criteria: [ ] Under one year of age with tracheostomy; [ ] Small tracheostomy tube and tracheostomy dependent; [ ] Obstructive airway spells resulting in cardio-respiratory decompensation (please attach separate sheet with explanation).
2. Infant, child or youth who is tracheostomy and/or ventilator dependent: [ ] Does not fit the criteria in #1 above, but is at risk of respiratory compromise during times when not directly observed by a trained caregiver.
3. Infant with chronic lung disease: [ ] Requiring higher amounts of oxygen (approx. >= 250 ml/min) with little respiratory reserve; [ ] Discharged to an isolated community without access to weekly oximetry monitoring.
4. Infant, child or youth with chronic lung disease requiring oxygen: [ ] During periods of active oxygen weaning (e.g. approximately 1-2 weeks); [ ] To facilitate early discharge from hospital (please attach a separate sheet with explanation).
5. Infant, child or youth who has a progressive neuromuscular disease with respiratory decline: [ ] Treatment plan and intervention for respiratory-related episodes are guided and quantified by the child's oxygen saturation and clinical manifestation.
6. Other [ ] If the child's needs do not fit into categories 1-5, please attach a separate sheet documenting the need for an oximeter. Be sure to include the following information:
- A thorough description of the child's condition and how this relates to the need for an oximeter;
- How and when the oximeter will be used;
- What interventions will be provided based on the cardio-respiratory assessment.

Requests outside of categories 1-5 above will be considered on an individual basis.

**SECTION 3 DELIVERY INFORMATION**

The Oximeter will be delivered to a hospital **or** the office of the prescribing health professional (please indicate preference and location for delivery details below). The prescribing health professional is responsible for training and releasing the oximeter to the child's parents and/or caregivers when training is complete.

Oximeter to be delivered to (please fill out address details below):

hospital                       prescribing health professional

RECEIVER CONTACT NAME		POSITION TITLE/PROFESSION	
ADDRESS		CITY/TOWN	POSTAL CODE
PHONE NUMBER (     )	FAX NUMBER (     )	EMAIL ADDRESS (IF APPLICABLE)	

**SECTION 4 PRESCRIBING HEALTH PROFESSIONAL INFORMATION AND ACKNOWLEDGEMENT OF RESPONSIBILITY**

NAME OF PRESCRIBING HEALTH PROFESSIONAL		POSITION TITLE	
ADDRESS (IF DIFFERENT THAN OXIMETER DELIVERY ADDRESS ABOVE)		CITY/TOWN	POSTAL CODE
PHONE NUMBER (     )	FAX NUMBER (     )	EMAIL ADDRESS	

NAME OF COMMUNITY PHYSICIAN (IF DIFFERENT)	PHONE NUMBER (     )	FAX NUMBER (     )
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As the prescribing health professional, I accept responsibility for the following:

1. Coordinating members of the child's health care team to provide client-specific training in use of the oximeter to the child's parent(s) and/or caregiver(s).
2. Ensuring that child-specific default alarm settings have been saved on the oximeter.
3. Releasing the oximeter to the child's parent(s) and/or caregivers when training is complete and parent(s)/caregiver(s) demonstrate competence in using the oximeter.
4. Coordinating ongoing follow-up to monitor the child's health and coordinating appropriate discontinuation of oximetry **OR** referring the child to a community physician (see above) who will assume responsibility for ongoing follow-up and discontinuation of oximetry.

SIGNATURE OF PRESCRIBING HEALTH PROFESSIONAL	DATE (YYYY/MM/DD)
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**FAX COMPLETED FORM TO: Medical Benefits Program at 250-356-2159**

Requests will be processed Monday to Friday. Please allow 10 working days for routine requests. **Urgent** requests will be processed as quickly as possible. **Please indicate clearly on the fax cover sheet if the request is urgent.**