CareicaHealth
OXYGEN

Toll Free: 1-855-672-6262
Fax: 204-822-3852

Request For Home Oxygen Service

DATE ______ / ______ / ______ (DD MM YY)

PLEASE BE ADVISED THAT THE CLIENT HAS MET ELIGIBILITY FOR THE FOLLOWING PROGRAM:

☐ FNIH ☐ PCDAP ☐ Private ☐ Other ____________________

CLIENT INFORMATION

MB Health # ____________ PHIN ____________ Treaty # ____________

Name (Last, First) ____________________

Address ____________________ Phone Number ____________________

Postal Code ____________________ Birthdate (D/M/Y) ____ / ____ / ____ Sex ______

Client's Physician ____________________ Phone Number ____________________

Hospital / Location ____________________ Phone Number ____________________

Hospital Contact ____________________ Phone Number ____________________

Hospital RRT ____________________ Phone Number ____________________

OXYGEN PRESCRIPTION (Please attach a copy of the prescription indicating litre flow & hours of use / day)

☐ O_2 Continuous at ____________ LPM.
☐ O_2 at Rest ____________ LPM.
☐ O_2 at Night ____________ LPM.
☐ O_2 with Exercise at ____________ LPM.
☐ O_2 PRN at ____________ LPM.
☐ O_2 with CPAP / BiPAP ____________ LPM.

Respiratory Diagnosis ____________________

Has "In Hospital" Training Been Completed? ☐ Y ☐ N ☐ Unsure

MENTAL STATUS

☐ Alert ☐ Confused ☐ Oriented ☐ Cognitively Impaired ☐ Anxious ☐ Nervous

MOBILITY

☐ Independent Uses Aides: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other ____________

HOME / DWELLING

☐ Apartment ☐ *Elevator* ☐ *(or) Stairs* ☐ House ☐ *Bungalow* ☐ *(or) 2-Storey*

Are there safety concerns in the client's home? ☐ Y ☐ N If Yes, ____________________

PRIMARY SUPPORT

☐ Self (If self, do not fill out additional information)

☐ Spouse ☐ Child ☐ Friend ☐ Relative Name ____________ Phone ____________

☐ Child ☐ Friend ☐ Relative Name ____________ Phone ____________

Does the client speak English? ☐ Y ☐ N Do the client's support person(s) speak English? ☐ Y ☐ N ____________

Authorized Referrer (Print) ____________ Signature ____________ Phone ____________

Case Coordinator (Print) ____________ Signature ____________ Phone ____________

CareicaHealth OXYGEN

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ACCREDITED WITH COMMENDATION ACCREDITATION AGREEMENT CANADA

Request For Removal of Service

DATE ______ ______ ______
DD MM YY

CLIENT INFORMATION

First Name ______________________

Last Name ______________________

Address ______________________

____

Postal Code ______________________

Birth Date ______ / ______ / ______ (DD MM YY)

Sex ☐ M ☐ F

Date ______ / ______ / ______ (DD MM YY)

Phone Number ______________________

MB Health Number ______________________

PHIN ______________________

Treaty Number ______________________

REMOVAL INFORMATION

Please be advised that the equipment and supplies that were installed in the client's home listed above are no longer required as a result of: ______________________

To arrange a convenient time to remove this equipment, please contact the following:

Name ______________________

Phone Number ______________________

Relationship to Client ______________________

Comments (e.g: special considerations with respect to timing of the removal)

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Upon completion of the equipment removal, please forward a copy of your "Equipment Removal Report" to my attention.

Request Made By:

Name ______________________

Signature ______________________

Position ______________________

Region ______________________