



## NIHB OXYGEN AND RESPIRATORY MEDICAL SUPPLIES AND EQUIPMENT PRIOR APPROVAL FORM

Please check box if appropriate:  Palliative Care Client OR  Expected date of discharge from Health Care facility: \_\_\_\_\_

**Section 1: Client Information**

Initial  Renewal

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID #:	Band #:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Address:		Phone #:
City:	Province / Territory:	Postal Code :

**Section 2: Parent/ Legal Guardian/ Representative** (If the client is under 18 months of age and not registered, please provide parent's information.)

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID#:	Band #:	Phone #:

**Section 3: Prescriber Information** (PLEASE PRINT)

Name and Title:	Licence #:
Phone #:	Fax #:

**Section 4: Client Health Information**

Diagnosis:	<b>Complications:</b> <input type="checkbox"/> Cor Pulmonale	<input type="checkbox"/> Pulmonary Hypertension	<input type="checkbox"/> Secondary Polycythemia, indicate Hematocrit % _____		
Is the benefit requested due to the result of an injury: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:		<b>Oxygen Prescription (OXYGEN ONLY)</b>	Rest	Exertion	Sleep
Where did the injury occur: Home <input type="checkbox"/> Work <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other <input type="checkbox"/>	When did the injury occur:	Oxygen flow rate, LPM			
Are any of these expenses covered under any other federal, provincial, territorial or private health care plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide the details:		Number of hrs /day			

**Section 5: Arterial Blood Gas and /or Oxygen Tests** (OXYGEN ONLY)

(Signed and dated oximetry test must accompany this form if PaO2 is greater than 55mmHg. Future signed and dated oximetry tests may be requested by NIHB for assessment. ABG results are required for initial oxygen set up, as well as the three month and one year assessments.)

ABGs on room air: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, specify % _____ flowrate.					Oximetry (SpO2) Test Results on Room Air (print outs of oximetry test results, signed and dated, must accompany this form)		
Date	pH	PaO2 (mmHg)	PaCO2 (mmHg)	SaO2	Rest	Exertion	Sleep
					Date:	Date:	Date:

**Section 6: Benefit Requested**

**START DATE:**

**END DATE:**

Description of Benefit	Benefit Code	Quantity	Cost	Manufacturer Name, Item Code # and Type

**Section 7: Provider Information** (PLEASE PRINT)

Name and Title:	Provider #:
Phone #:	Fax #:

I hereby certify that the information provided above is true and complete. The NIHB Program reserves the right to request this form for audit purposes.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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