

HOME OXYGEN PROGRAM (HOP) APPLICATION

PH: (250) 370-8840 / Toll Free: 1-866-370-8840



Application must be completed in full and faxed (complete with hard-copy lab data) directly to an HOP contracted vendor.

1. Date of Application: _____

Hospital Discharge Date: _____

2. Client Data:

PHN: _____ Last name First name Middle name D.O.B (dd/mm/yy): _____ Gender: M <input type="checkbox"/> F <input type="checkbox"/> Street Address: _____ City: _____ Postal Code: _____ Phone: _____ Contact/Next of Kin: _____ Phone: _____ Extended Health Benefits / Third Party Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Agency: <input type="checkbox"/> PBC <input type="checkbox"/> Sun Life <input type="checkbox"/> VAC <input type="checkbox"/> NIHB <input type="checkbox"/> Other	Referring Physician: _____ Dr. _____ Doctor No. _____ Street Address: _____ City: _____ Postal Code _____ Phone: _____ Fax: _____ Other Physicians involved: <input type="checkbox"/> Respirologist <input type="checkbox"/> Internist Dr: _____ Fax: _____ Dr: _____ Fax: _____
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3. Clinical Information: Note: A "palliative" diagnosis does not ensure HOP subsidy approval.

Primary Diagnosis: _____ <input type="checkbox"/> Advanced COPD <input type="checkbox"/> Interstitial Lung Disease <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other: _____	Secondary Diagnosis: _____ <input type="checkbox"/> Clinically significant CHF <input type="checkbox"/> Cor pulmonale <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Polycythemia _____ g/dl	Other Information: <input type="checkbox"/> Trach <input type="checkbox"/> OSA <input type="checkbox"/> BiPAP/CPAP _____ cms Smoker: <input type="checkbox"/> yes <input type="checkbox"/> no
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4. Laboratory Data: NB: Diagnostic data must be obtained < 48 hours from date of application and hardcopy must be attached.

Test	Date (dd/mm/yy)	Hard Copy Study Attached	O ₂ Flow.	O ₂ Sat	pH	PaCO ₂	PaO ₂	HCO ₃	BE
ABG		<input type="checkbox"/>							
ABG		<input type="checkbox"/>							
Resting Oximetry		<input type="checkbox"/>			Other Information:				
Ambulatory Oximetry		<input type="checkbox"/>							
Nocturnal Oximetry		<input type="checkbox"/>							

5. Current Medications and/or Other Therapies:

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

6. Application Source:

<input type="checkbox"/> Hospital <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other: _____ Application completed by: _____ (Name, title) Phone: _____	Hospital: _____ Ward: _____ Oxygen Supplier: _____ Application sent/faxed to Vendor: <input type="checkbox"/> Yes <input type="checkbox"/> No
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7. Oxygen Prescription: Oxygen flow rate to maintain Oxygen Saturation ≥ 90%

At Rest: _____ l/min. With Ambulation: _____ l/min. Nocturnal: _____ l/min. For: _____ hrs/day

Physician's Signature:(mandatory) _____

Date: _____

8. HOP Subsidy Review: For HOP use only

Signature: _____	Date: _____	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
Usage: <input type="checkbox"/> Short Term Continuous <input type="checkbox"/> Long Term Continuous: <input type="checkbox"/> Nocturnal <input type="checkbox"/> Short Term Ambulation <input type="checkbox"/> Long Term Ambulation		
Date of Reassessment: <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> Other		

Notes: _____