



FORM MUST BE COMPLETED BY THE ATTENDING BC SPECIALIST AND MUST INCLUDE THEIR SIGNATURE OR IT IS CONSIDERED TO BE INCOMPLETE

For detailed information about Guidelines for Funding Approval see: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html

DATE OF APPLICATION

PHYSICIAN INFORMATION

Form with fields: NAME OF REFERRING SPECIALIST PHYSICIAN, PRACTITIONER NUMBER, SPECIALTY, ADDRESS, PHONE NUMBER, FAX NUMBER

PATIENT INFORMATION

Form with fields: SURNAME, FIRST NAME, INITIALS, PERSONAL HEALTH NUMBER, DATE OF BIRTH, ADDRESS

CLINICAL DIAGNOSIS (CONDITIONS FOR WHICH TREATMENT IS RECOMMENDED):

NAME(S) AND SPECIALTY(S) OF OTHER BC AND CANADIAN SPECIALISTS CONSULTED FOR THIS MEDICAL CONDITION (PLEASE ATTACH CONSULTATION REPORTS AND MEDICAL RECOMMENDATION(S) TO SUPPORT THE MEDICALLY REQUIRED SERVICES FOR OUT-OF-COUNTRY MEDICAL SERVICES)

PROPOSED TREATMENT AND/OR PROCEDURE FOR WHICH APPROVAL IS REQUESTED:

PROPOSED OUT OF COUNTRY FACILITY/PHYSICIAN NAME AND ADDRESS

Form with fields: APPLICATION IS FOR: (checkboxes for In Patient Services, Out Patient Services), FACILITY IS: (checkboxes for Public, Private, Unknown), SPECIALTY OF PHYSICIAN

<p>IS TREATMENT FOR CANCER?</p> <p><input type="checkbox"/> NO    <input type="checkbox"/> YES (ATTACH A COPY OF THE MEDICAL RECOMMENDATION FROM THE BC CANCER AGENCY)</p>	<p>IS THE OOC TREATMENT GENERALLY ACCEPTED IN BC AS APPROPRIATE IN THIS MEDICAL CONDITION?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	<p>IS THIS TREATMENT IN THE DEVELOPMENTAL / EXPERIMENTAL STAGES?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
<p>IS TREATMENT AVAILABLE FOR THIS CONDITION IN:</p> <p><input type="checkbox"/> BRITISH COLUMBIA <i>WHERE IS TREATMENT PERFORMED?</i></p> <hr/> <p><input type="checkbox"/> ELSEWHERE IN CANADA <i>WHERE IS TREATMENT PERFORMED?</i></p>		
<p>IS TREATMENT OF THIS CONDITION REQUIRED OUT OF CANADA TO AVOID A DELAY IN OBTAINING TREATMENT IN BC?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	<p>DELAY WILL RESULT IN:</p> <p><input type="checkbox"/> DEATH</p> <p><input type="checkbox"/> MEDICALLY SIGNIFICANT IRREVERSIBLE TISSUE DAMAGE</p>	
<p>HOW SOON IS TREATMENT REQUIRED? (PLEASE EXPLAIN MEDICAL URGENCY)</p>		
<p>COMMENTS</p>		

**Completion of this form does not guarantee funding for out-of-province/country medical services.**

<p>IS THE OUT-OF-COUNTRY TREATMENT REQUIRED AS A RESULT OF:</p> <p><input type="checkbox"/> A WORK RELATED ACCIDENT</p> <p><input type="checkbox"/> A MOTOR VEHICLE ACCIDENT</p>	<p>REFERRING PHYSICIAN'S SIGNATURE</p>
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