

Application for Temporary SAIL Oxygen Funding

Date: _____

FOR HOSPITAL DISCHARGE ONLY

Not available to patients applying from the community. Coverage is limited to up to one month.

Patient Identification

Name: _____ Health Services Number: _____

Telephone: _____ Date of Birth: _____

Street Address or P.O. Box: _____ City/Town: _____

Province: _____ Postal Code: _____

Hospital Discharge Information

Discharging hospital: _____ Unit/program: _____

Expected discharge date: _____ Hospital telephone / extension: _____

Diagnosis: _____

Eligibility and Required Conditions**Temporary oxygen is required at discharge following (select one):**

- ☐ an acute cardiorespiratory hospitalization.
- ☐ hospitalization for a respiratory illness resulting in a temporary need for oxygen at discharge.

Complete all remaining eligibility criteria below. Qualifying oxygen testing is not required for this temporary benefit.

- ☐ The prescriber expects the need for oxygen to be temporary.
- ☐ Oxygen is required to support discharge home.
- ☐ Patient does not currently have approved short-term or long-term SAIL oxygen coverage.
- ☐ A referral for reassessment testing has been initiated before discharge.
- ☐ This application is completed by the hospital care team as part of the discharge process.

Temporary Oxygen Prescription

Complete the prescription details below.

☐ Continuous oxygen ☐ Exertional oxygen Flow rate: _____ L/min

☐ Nasal cannula Other method: _____

Hospital Prescriber

Name: _____ ☐ Physician ☐ Nurse practitioner

Hospital telephone / extension: _____ Date signed: _____

Prescriber signature: _____

Patient Supplier Selection

Select one supplier. Vendor changes are not permitted during temporary coverage.

- ☐ Careica Health ☐ Medigas ☐ Prairie Oxygen Ltd.