

Is the out-of-country treatment required as a result of a work-related accident? yes no

If yes, please contact the Workplace Safety and Insurance Board to discuss coverage as OHIP does not insure service to which a person is entitled under the Workplace Safety and Insurance Act.

Part 1 to 5 of this form must be completed and signed by an attending Ontario Physician.
Return to the nearest Ministry of Health and Long-Term Care office. *Attention: Medical Consultant.*

For Ministry use only

Decision

Date rec'd

Year	Month	Day

Reference number

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Confidential when completed

Part 1 – Patient

Last name			First name			Initials			
Date of birth <small>Year Month Day</small>		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Health Number			Version		
Address (Street number and name, R.R., P.O. Box, General delivery)									
City				Province			Postal Code		
Telephone no. (Home) ()			Telephone no. (Business/ Daytime) ()			Ext.			
Parent / Legal Guardian's last name (if applicable)				Parent / Legal Guardian's first name (if applicable)					
Where this form is signed by a person who is not the applicant, indicate the relationship between the applicant and the person completing the form: <input type="checkbox"/> parent of child under 16 years of age <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney under power of attorney <input type="checkbox"/> other (specify) _____ <i>If legal guardian, attorney or other, please provide copy of document which establishes that status.</i>									

Part 2 – Referring Ontario Physician

Last name			First name		
Office address (Street number and name, R.R., P.O. Box, General delivery)					
City			Province		Postal Code
Telephone number ()		Ext.	Provider number		Diagnostic code
Fax number ()		Email address			
Clinical diagnosis (condition for which treatment is sought)					
Names of all other Ontario physicians consulted concerning this condition. Please attach copies of all relevant documentation and consultation letters.					
Proposed treatment and/or procedure for which prior approval is requested:					

Please (✓) whether the application is for:

Lab services Outpatient services Inpatient services ▶

No. of days anticipated for hospitalization

Year	Month	Day

Provide anticipated admission date

Year	Month	Day

Where a lengthy admission is anticipated, provide reasons to support the admission. (Provide attachments or supporting documentation if necessary)

Part 3 – Proposed Out-of-Country Health Facility/Hospital

Facility		
Address (Street number and name, R.R., P.O. Box, General delivery)		
City		State/Country
Code		
Out-of-Country Physician or other contact person		Telephone number ()
Ext.		
Email address		Fax number ()

Collection of this information and information in any attached record(s) is for the assessment and verification of eligibility for funding/payment and for the administration of the Health Insurance Act. It is collected/used for these purposes under the authority of the Ministry of Health and Long-Term Care Act, section 6(2)(d) and sections 4.1 and 37 under the Health Insurance Act. For information about collection practices, contact the Director, Provider Services Branch at 1-866-684-8620 or write to your local Ministry of Health and Long-Term Care office.

Part 4A – For treatment performed in Ontario

Is this treatment generally accepted in Ontario as appropriate for a person in these medical circumstances?

Yes No

Is this treatment performed in Ontario by an identical or equivalent procedure?

Yes No

If "Yes", where is this service performed in Ontario?

Is this treatment required out of Canada to avoid a delay in obtaining the treatment in Ontario that would:

a) Result in death? Yes No

b) Result in medically significant irreversible tissue damage? Yes No

If "Yes" to either of the above, how soon is the treatment required?

If tissue damage is reasonably expected to result from delay, describe the type of damage:

Name of physician contacted to determine availability of treatment:

Estimated length of waiting period in Ontario
Weeks

Was this a CritiCall transfer?
 Yes No

If this is a request for an **organ transplant**, give the name of the person contacted at Trillium Gift of Life Network, 1 800 263-2833.

If this request is for **cancer** treatment, give the name of the specialist contacted at the nearest Regional Cancer Centre.

If this request is for **cardiac care** treatment, give the name of the person contacted at the Cardiac Care Network of Ontario, 1 416 512-7472.

If this request is for **substance abuse** treatment, give the name of the referral agent contacted at the Drug and Alcohol Registry of Treatment, 1 800 565-8603.

OR

Part 4B – For treatment not performed in Ontario

Is this treatment generally accepted in Ontario as appropriate for a person in these medical circumstances?

Yes No

Is this treatment generally accepted as experimental in Ontario?

Yes No

Is this treatment performed in Ontario by an identical or equivalent procedure?

Yes No

Please provide details if this treatment is not performed in Ontario (*include names of physicians and/or health facilities contacted in Ontario to determine whether treatment is performed*):

Comments:

Part 5 – Follow-up Care

For patients requiring ongoing long-term care, please provide details relative to your short and long-term plans for follow-up care to be provided in Ontario should payment for out-of-country treatment be approved:

IT IS AN OFFENCE TO KNOWINGLY GIVE FALSE INFORMATION TO THE MINISTRY OF HEALTH AND LONG-TERM CARE IN ANY APPLICATION OR STATEMENT.

All accompanying documents will be considered as part of this application. I hereby declare the information in this application to be true and authorize the Ministry of Health and Long-Term Care or its agents to collect, use and disclose all information or records relating to this application, or attached to it, to assess the request, to negotiate payment for out-of-country services and to assist in repatriating me to Ontario, should this become necessary. I understand that all information or records relating to this application may be disclosed to other Ontario ministries and to external health care providers, institutions and agencies, as is determined to be necessary by the Ministry of Health and Long-Term Care. I understand that written approval or denial of this application will be sent directly to the referring physician only.

Name of parent/guardian or patient (*print or type*)

Signature of parent/guardian or patient

Date

I hereby declare the information provided by me to be true.

Signature of referring physician

Date