

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: _____

Home Oxygen Program (HOP) Criteria and Information

1. TERMS:

- By signing this form you are (A) Completing a prescription for oxygen, (B) Ensuring all information provided is accurate, and (C) Acknowledging the terms and ongoing involvement of HOP with this client.
- Completing this form does not ensure that a subsidy will be granted.
- Successful applicants will be granted an oxygen system consistent with the client's clinical needs. You do not need to choose the oxygen equipment; it will be determined for you.
- HOP Respiratory Therapists will provide periodic assessments, and oxygen titration. At-home testing may include arterial blood gas, resting, ambulatory and nocturnal oximetry.
- Extended Health Benefits, Veterans Affairs Canada (VAC), NIHB, ICBC and WCB providers are the primary sources of funding for home oxygen, not the HOP.

2. BC Home Oxygen Medical Criteria:

Provide as much recent and appropriate information as possible. Data submitted must be taken within 48 hours of application with acute discharges. Oximetry data shown as a single digit will not be accepted. All HOP subsidy applicants are expected to seek and be compliant with optimal medical treatment

1.0 Resting: Patients must be rested on room air for a minimum of 10 minutes prior to obtaining an **arterial blood gas** (ABG) sample.
A. An ABG with a partial pressure of arterial oxygen (PaO_2) \leq 55 mmHg on room air. **Note:** In exceptional circumstances an arterial oxygen saturation measured by pulse oximetry (SpO_2) $<$ 88% sustained continuously for 6 minutes may be accepted.

OR

B. An ABG with a PaO_2 of 60 mmHg or less, with evidence of one of the following conditions:

1) Clinically significant CHF, **2)** Cor pulmonale, **3)** Pulmonary hypertension **4)** Polycythemia

2.0 Nocturnal: Obstructive Sleep Apnea (OSA) must be ruled out or maximally treated.

A. SpO_2 $<$ 88% for $>$ than 30% of a minimum 4- hour nocturnal oximetry study.

OR

B. SpO_2 $<$ 88% for $>$ than 20% of a minimum 4-hour nocturnal oximetry study, with evidence of one of the following conditions:

1) Clinically significant CHF, **2)** Cor pulmonale, **3)** Pulmonary hypertension **4)** Polycythemia

3.0 Short Term Oxygen Therapy for Ambulation: A SpO_2 $<$ 88% sustained continuously for a minimum of one minute during the patient's usual type of ambulation on a level surface. **Note:** **a.** The maximum test time shall be 6 minutes. **b.** Tests shall not include post-ambulation oxygen saturation dips.

4.0 Long Term Oxygen Therapy for Ambulation: The Home Oxygen Program or an accredited Pulmonary Lab will perform the required testing for Long Term Oxygen Therapy for Ambulation. Clients must continue to meet short-term oxygen criteria for ambulation with evidence of one of the following: (either **A** or **B**)

A. A measured improvement in a 6-minute walk test (as tolerated on a level surface) on oxygen compared to air so that the distance traveled increases by at least 25% and at least 30 meters or 100 feet **AND** A 3 point reduction in dyspnea as per the 7- Point Borg scale on oxygen compared to room air

OR

B. A SpO_2 $<$ 80% with ambulation

Separate qualifying criteria may exist for subsidies involving infants and children. In general, Neonatologists or Pediatricians determine the chronic needs for oxygen for infants and children.

3. Non-Medical Eligibility Criteria:

- Must be a BC citizen for more than 3 months.
- Must be eligible for and have valid BC Medical Services Plan coverage.
- Must spend \geq 6 months of a calendar year and continue to maintain their home in BC to maintain BC MSP coverage.
- Must be a permanent resident of the VIHA, and not reside in a facility governed by the Hospital Act.
- Must be capable of handling oxygen safely in the home.
- The referring physician must sign the application.
- Applications involving Veterans Affairs Canada (VAC) may be reviewed by HOP then submitted to VAC for further processing.

HOP will not provide client funding:

- If above eligibility criteria are not met.
- For placebo effects.
- After the second reported Safety offence.
- For misuse of oxygen or equipment.
- To operate nebulizers.
- For outpatient use from a hospital.
- For travel outside of Canada.
- For noncompliance with the prescription or terms of the HOP
- Workers Compensation and ICBC claimants

Approved funding for oxygen will be granted for a limited time. For continued subsidization, clients are required to sustain eligibility requirements at each home assessment completed by the HOP Respiratory Therapist.

Indications for home oxygen funding will be reviewed and updated as necessary to reflect changing requirements and accepted medical practice.

4. Process:

Acute and Community referrals: Once the application is completed in FULL, contact a home oxygen vendor by phone and establish setup timeframe and fax the form and any additional clinical data to the vendor.