LAO GARMENT PROGRAM - APPLICATION

DATE: _____

REFERRED BY: _____

CRITERIA: Eligible lymphedema patients must apply in writing to the LAO outlining their need for financial assistance in the form of a letter and this completed form and any attached documents required as requested below

SUBMITTED BY:

Patient Name: _____

Patient Signature: _____

Date Signed: _____

PATIENT INFORMATION:

I AM A CANADIAN CITIZEN OR PERMANENT RESIDENT ONTARIO: Yes ▢ No ▢

IF YES, HOW LONG: Years _____ Months _____

OHIP#: _____

NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

PATIENT INFORMATION continued……

ALTERNATE CONTACT: _____

PHONE NUMBER: _____

RELATIONSHIP: _____

CLINICIAN INFORMATION:

PHYSICIAN (FAMILY DOCTOR) OR ONCOLOGIST: _____

PHONE NUMBER: _____

OFFICE/CLINIC ADDRESS: _____

PHYSICIAN'S PRESCRIPTION DETAILING REQUIRED GARMENT MUST ACCOMPANY APPLICATION

REFERRING LYMPHEDEMA TRAINED THERAPIST/FITTER:

NAME: _____

PHONE NUMBER: _____

THERAPIST RECOMMENDATION FOR REQUIRED GARMENT (OFF THE SHELF) or RETAILER/FITTER RECOMMENDATION FOR REQUIRED GARMENT MUST ACCOMPANY APPLICATION

INFORMATION/DOCUMENTATION TO ACCOMPANY APPLICATION

The following information and documentation must accompany application:

- ☐ REFERRAL LETTER FROM FAMILY DOCTOR AND LYMPHEDEMA TRAINED THERAPIST
- ☐ NAME OF THE COMPANY AND THE POLICY NUMBER OF ANY HEALTH INSURANCE PROGRAMS, PRIVATE OR GROUP INSURANCE BENEFITS, INCLUDING LETTER OF CLAIM REFUSAL
- ☐ PROOF OF INCOME STATUS, PROVIDING EVIDENCE OF COMBINED HOUSEHOLD INCOME (I.E. NOTICE OF ASSESSMENT, T1 OR ODSP STATEMENT)

LAO GARMENT PROGRAM CONSENT FORM

This consent form will be maintained confidentially in your file. This form covers the application for your present condition, as well as any documents attached. Please take the time to read and check if fully understood.

CONSENT TO THE COLLECTION OF INFORMATION:

All personal information, assessment information and records will be safeguarded and remain confidential. Any personal health information collected will remain confidential as per the Personal Health Information Protection Act, 2004.

I _____:

- ☐ Give my consent for the collection of personal information.
- ☐ Agree that the information provided is true to the best of my knowledge.
- ☐ Understand the information I have provided on this form is confidential and will not be released without my written consent.
    - ☐ I consent to the Lymphedema Association of Ontario and its representatives sharing the information provided in my application, if necessary, with the Physician(s) (Family Doctor/Oncologist) noted and/or other health care professionals for the purpose of processing my application and in provision of the goods and services applied for.
    - ☐ I do not consent to the sharing of my information.

_____ _____

Signature Date

Name: _____