Clear Form

Health PEI
One Island Health System

HEALTH CARE PROVIDER FORM
OSTOMY SUPPLIES PROGRAM REGISTRATION

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – HEALTH CARE PROVIDER INFORMATION

NAME AND MAILING ADDRESS

PHONE NUMBER (INCLUDE AREA CODE):

FAX NUMBER (INCLUDE AREA CODE):

- ☐ Physician
- ☐ Nurse Practitioner
- ☐ NSWOC
- ☐ Other (Please specify) :

SECTION 2 – PATIENT INFORMATION

PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)

PATIENT'S MAILING ADDRESS

SECTION 3 – TYPE OF OSTOMY

- ☐ Temporary
- ☐ Permanent

Date of surgery_____

- ☐ Permanent Colostomy
- ☐ Permanent Ileostomy
- ☐ Permanent Fecal Continent Reservoir
- ☐ Permanent Urostomy
- ☐ Permanent Urinary Continent Reservoir

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under PEI Pharmacare Drug Programs.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

HEALTH CARE PROVIDER SIGNATURE (REQUIRED) **DATE**

DECEMBER 2018

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.