Out of Province Assessment/Treatment Request Form for:

Mental Health Services ● Alcohol and Drug Services ● Problem Gambling Services ● Acquired Brain Injury Services ● Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech Language Pathology, Podiatry)

All Fields Must Be Completed:

Client Name:_____

Saskatchewan Personal Health Number: _____

Client Address: _____

Referring Health Care Provider:_____

Note: This person is responsible for coordination of the admission to the program/service and follow up treatment/ assessment/monitoring progress upon return to the province.

Title: _____

Program Area: _____

Address:_____

Email: _____

Phone Number: _____

Is this client currently receiving out of province assessment and/or treatment services or requesting reimbursement for services accessed out of province? ☐ **Yes** ☐ **No**

NOTE: If response is **YES**, **DISCONTINUE APPLICATION**. Prior approval is required for out of province treatment/assessment. Request will be denied as prior approval was not obtained.

1. Seeking services for: *Check all that apply*

- ☐ Assessment
- ☐ Consultation
- ☐ Treatment

2. Seeking services in the area of: *Check all that apply*

- ☐ Mental Health
- ☐ Alcohol misuse
- ☐ Drug misuse
- ☐ Problem Gambling
- ☐ Acquired Brain Injury Rehabilitation
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech and Language Therapy
- ☐ Podiatry
- ☐ Other

Other: *Please Specify*:

3. Summary of completed assessments, screening tools and other investigations as they relate to the services being requested.

Assessment/Screen Completed	Brief Description of Results	Additional Comments

4. Summarize the current services provided to the client over the last 12 months as they relate to the services being requested.

Service Provided	Frequency of Service	Goals for Service	Additional Comments

5. Have all the services and supports required to meet the needs of your client been accessed and investigated within the province? ☐ **Yes** ☐ **No**

NOTE: If response is **NO**, **DISCONTINUE APPLICATION**. All in province services must be accessed before out of province services can be considered.

6. Why is support for out of province treatment/assessment being requested? *Check all that apply*

- ☐ Clinician requires additional expert advice on the case
- ☐ Service providers are not available within the province
- ☐ Service within the province has not provided positive outcomes for the client
- ☐ Client outcomes have plateaued and expertise assessment is not available within the province to determine next steps
- ☐ Client occupation necessitates treatment out of the province

7. Have the services being requested in this application been explored nationally? ☐ **Yes** ☐ **No**

If you responded **YES**, what was the result of your investigation?

If you responded **NO**, why are these services not being pursued within Canada?

8. Please provide an overview of the proposed treatment facility and the evidence based clinical information that supports the treatment model. Include details on the treatment program, services available, treatment model.

9. What is the clinical evidence based reasoning for choosing this program?

10. In addition to the service and/or facility being evidence-based, is it also (*check all that apply*):?

☐ Regulated ☐ Publicly-funded ☐ Accredited (by a recognized accreditation body)

11. Itemize all billable services expected to be provided including lab tests, treatment supplies, diagnostic costs, etc. All billable services must be listed here. Only services and items listed here will be covered. If additional services/items are required upon or during admission to the program, prior approval is required. **Please note: GST exempt**.

Service	Cost	Total For Service
Total Cost for Services		

12. Provide the follow up treatment plan including the service provider, where and how often.

Follow up Service	Provider and Location	Frequency of Service upon return to Province

13. Has the client given permission for the information contained in this application to be shared with the Ministry of Health for the purposes of considering out of province assessment/treatment services?

☐ **Yes** ☐ **No**

Send completed request forms to the **Physician Support Program (PSP)** or to the **SHA Regional Director** or **Executive Director for the service being requested**.

Example: *Mental Health and Addiction in Saskatoon, Primary Care in the southeast, etc.*

For SHA or PSP Use Only:

- ☐ Referred by a health care professional operating in the publicly-funded system
- ☐ Request meets the Ministry of Health's criteria within the Out-Of-Province Assessment and Treatment Policy
- ☐ SHA/PSP will be able to provide follow-up care, or any enhanced pre-treatment supports.

Approved by: _____ Date: _____

Send the Form to: ccb.oofp@health.gov.sk.ca

_____ _____

Signature of referring health care provider Date

SAVE AS
PRINT
RESET