Request for Coverage of a Non-Medical Escort

The Non-Insured Health Benefits (NIHB) policy for Non-Medical Escorts is found in Section 5.5 of the July 2005 NIHB *Medical Transportation Policy Framework.* The provision of a non-medical escort may be approved, following a physician's or community health professional's* **request** only when there is a legal or medical **requirement**. Non-medical escorts **cannot** be considered based on '**compassionate grounds**' (Section 12.1 Exclusions)

Section 1 - Client Information and Consent

Client's Full Name:____

Date of Birth:____/____/_____ Client ID #:________________________
dd / mm / yyyy

CLIENT CONSENT FOR RELEASE OF INFORMATION

I consent to the disclosure of any personal medical information to NIHB to support my request for coverage of a non-medical escort.

Client Signature: ______________________ **Date:**______________________

Section 2 - Medical Information

This section must be completed and signed by a Physician/Community Health Professional *

**Community Health Professional is a health professional who is a member in good standing of a professional association*

As the **treating** Physician/Community Health Professional I have assessed this client and verify the following: **Please complete all of the following questions.**

Y ☐ **N** ☐ **COGNITION**: Does the client have any limitations with memory, concentration, problem-solving, or safety awareness?

Y ☐ **N** ☐ **SENSES:** Does the client have any significant limitations with sight, hearing or speech?

Y ☐ **N** ☐ **SOCIAL FUNCTIONING:** Does the client have limitations dealing with other people (mental health issues?)

Y ☐ **N** ☐ **PERSONAL NEEDS:** Does the client have limitations in washing/dressing/eating independently?

Y ☐ **N** ☐ **RESPIRATORY FUNCTION:** Does the client have any breathing limitations?

Y ☐ **N** ☐ **BOWEL & BLADDER FUNCTION:** Does the client need help with toileting?

If YES to any of the above, please describe how this affects their ability to travel without a non-medical escort:

Y ☐ **N** ☐ Does the client require a mobility aid for walking?

Y ☐ **N** ☐ Are there any significant limitations to the client lifting/reaching as per normal daily activities?

Y ☐ **N** ☐ Are there any medical limitations to sitting or standing?

How long (in time **OR** distance) can this individual walk?

How does the client normally travel to your office?

If YES to any of the above, please describe:

What is the **main reason for you to recommend** a non-medical escort for this client?

What is the key risk if the client **is not covered** for a non-medical escort?

Please note any other relevant information about the client's medical condition:

Y ☐ **N** ☐ **LANGUAGE BARRIER:** Does the client have significant difficulty speaking and/or understanding English?

PLEASE SELECT OPTION #1 OR #2.

#1
As the treating health professional, **I consider it necessary for this client to have a non-medical escort covered** (check all that apply):

❑ while the client is travelling **both ways between home and their medical appointment/procedure**

❑ while the client is **admitted to hospital**, and I have explained above why hospital staff cannot fulfill their needs

❑ to travel home at the time of **discharge** after an admission to a medical facility

❑ while the client is **staying near the hospital**, as instructed, after surgery or during extended out-patient treatment

❑ other (please describe)_______________________________________

The anticipated duration this client will require a non-medical escort is (choose one):

❑ One Time only (date)_______________________________________

❑ Time Limited Period (duration - Start Date to End Date)_______________________________________

❑ Long Term (this needs confirmation that the above functional assessment is stable. To be reassessed by NIHB every year with updated medical information submitted from a physician/nurse praticitioner who is familiar with the client's medical history and treatment plan)

OR:

#2
❑ **I DO NOT consider it necessary for this client to have a non-medical escort covered**

Physician/Community Health Professional Signature____

Physician/Community Health Professional Name (please print):____

Role in Client's medical care:____

Physician/Community Health Professional Address:____

Telephone Number:(______)____________________ Date:____

Fax this completed form to:
Non-Insured Health Benefits, First Nations & Inuit Health Branch
Atlantic Regional Office, Health Canada
Suite 1525, 15th Floor, 1505 Barrington Street, Halifax, NS B3J 3Y6
Telephone: 1-800-565-3294 Fax: 1-866-963-7700