



# Palliative Care Drug Access Program Application

*The Palliative Care Drug Access Program's purpose is to facilitate access to eligible pharmaceuticals on a no cost basis to a terminally ill patient, who wishes to remain in the community as an alternative to requiring admission to a health care facility.*

### Section (A) Applicant's personal information (Please Print)

*I hereby request coverage under the Manitoba Health –Palliative Care Drug Access Program.*

Surname	First Name	Middle Name
Manitoba Health Registration Number	Personal Health Identification Number (PHIN)	
Mailing Address		
Postal Code	City/Town	Province
Patient's Signature		Date

### To be completed by guardian, legal representative or parent (if patient is under the age of 18)

I am the Patient's:  Guardian  Legal representative  Parent

Surname	First Name	
Signature	Date	Telephone No.

### Section (B) To be completed by the attending Physician

*I hereby certify that this patient meets the criteria for Palliative Care Drug Access Program.*

Patient's eligibility is contingent on meeting all enrolment criteria below :

- The applicant requires prescribed eligible pharmaceuticals to support the palliative care plan.
- The applicant's primary pharmaceutical needs are for comfort-focused care.
- The applicant and/or their family understand, and agree with the plan for comfort-focused care.

Attending Physician's Name (Please Print)	Physician's License No.	Telephone No.
Patient's Primary Diagnosis	Other Diagnosis	
Signature	Date	

### Section (C) To be completed by the Regional Health Authority Palliative Care Coordinator or Regional Designate

The applicant is enrolled in a Regional Health Authority Palliative Care Program and is receiving program services.

Palliative Program Enrolment Date: (dd/mm/yy)	Application Date to Drug Access Program:(dd/mm/yy)	Palliative Program Withdrawal Date: (dd/mm/yy)		
Palliative Coordinator Signature	Date	RHA No.	Telephone No.	Fax No.

### Office Use Only

Date Received from RHA	Effective Date	Notification of Withdrawal from RHA Receive Date		
Date RHA Notified	Verified By	DPIN Validation Completed	Verified By	

*In order to process this application as quickly as possible, please ensure information required is complete.*