VPRS Community Pelvic Health Treatment Plan Funding Request

This is a request for funding for a treatment plan. This form must be completed by a Registered Physical Therapist practicing in Pelvic Health after an Initial Assessment has been completed. Funding is not guaranteed. For funding for an Initial Assessment please complete the Community Pelvic Health Initial Assessment Funding Request.

Please email completed form to lauren@physicalrehabsociety.ca or fax to 778-910-4605

1. Treating Pelvic Health Physical Therapist's Name *

2. Treating Pelvic Health PT's Clinic *

3. Clinic Email *

4. Clinic Phone & Fax Number *

5. Applicant's Legal & Preferred Names *

6. Applicant's Email *

7. Applicant's Phone Number *

8. Applicant's Address *

9. Applicant's Sex *

10. Applicant's Gender *

11. Applicant's PHN *

12. Applicant's Date of Birth *

Example: January 7, 2019

13. Power of Attorney or Substitute Decision Maker Name & Contact Info (if applicable)

14. Reason for Funding Request *

Check all that apply.

- [ ] Low Income
- [ ] Disability
- [ ] Financial Hardship/Extraneous Circumstances

15. Reason for Request (must have at least 1 to qualify lasting 3 months or longer) *

Check all that apply.

- [ ] Incontinence (urinary and/or fecal)
- [ ] Pelvic Organ Prolapse
- [ ] Dyspareunia/vaginismus/vulvodynia/vestibulodynia
- [ ] Pelvic Pain and/or Endometriosis
- [ ] Painful Bladder Syndrome/Interstitial Cystitis
- [ ] Post-op uro and/or gynecological surgery

16. In-Home/Community Physio Required? (Difficulty leaving the home) *

- [ ] Yes
- [ ] No, in-clinic physio is suitable
- [ ] Maybe

17. Please outline the total number of treatment sessions being requested excluding the initial assessment (up to a maximum of 6 in one calendar year). *

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18. Please outline your current clinic fee/subsequent visit. *

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19. Does this applicant qualify for MSP funded physiotherapy

- [ ] Yes
- [ ] No

20. Does this applicant have extended health insurance

- [ ] Yes
- [ ] No

21. *Declaration & Disclaimer:*

I confirm that the information provided is accurate and complete to the best of my knowledge. I acknowledge that VPRS is not responsible for verifying this information but reserves the right to request supporting documentation at any time. Failure to provide requested documentation may impact eligibility for funding or participation in the network.

I confirm that our clinic has obtained informed consent from the client for the collection, use, and disclosure of their personal health information to VPRS for the purposes of assessing this funding request, in accordance with applicable privacy legislation (HIPAA, PIPA, PIPEDA).

- [ ] Yes

22. PT Signature & Date