



First Nations Health Authority
Health through wellness

PHYSICIAN ESCORT FORM

Date:	PLEASE RETURN THIS TO THE TRAVEL COORDINATOR LISTED BELOW:
Attn:	Name: _____
	Organization: _____
	Fax: _____
Client Name:	Date of Birth:
<p>The First Nations Health Authority, Health Benefits provides Medical Transportation benefits to assist clients to access medically required health services that cannot be obtained on the reserve or in the community of residence. One of the benefits that may be considered for funding is the provision of an escort.</p> <p>The Program may assist for non-medical escorts to travel with clients who are unable to travel alone for medical or legal reasons and may be approved upon receipt of a physician's verification identifying that the patient requires an escort. The FNHA Health Benefits Program excludes compassionate travel (such as client does not like to travel alone) or where the client is under the care of the hospital or long term care facility.</p> <p>One of the criteria under the Program is that clients requiring an escort has this form filled out and signed by a physician certify that the client named above has a medical condition that requires an escort for the following reason(s):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Client has a physical/mental disability such that he or she requires assistance with activities of daily living, such as bathing, dressing, feeding and decision-making. (briefly describe below why and how the escort would be assisting the client). <input type="checkbox"/> Client requires assistance with all his/her activities of daily living as a result of a current medical condition (briefly describe below why and how the escort would be assisting the client). <input type="checkbox"/> Client needs a translator (i.e. client does not speak or understand English) <input type="checkbox"/> A family member requires instructions on necessary medical procedures that cannot be given to the client alone (briefly describe what instructions are being given). <input type="checkbox"/> General Anaesthesia (Day Surgery) 	
Description:	
Physician's Name (Please print clearly)	Physicians Signature:



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CONFIRMATION OF ATTENDANCE FORM
PERSONAL AND CONFIDENTIAL

To be completed by Health Professional or Health Facility and fax to 1-888-299-9222

The First Nations Health Authority, Health Benefits, provides Medical Transportation Benefits to assist First Nations clients, who are residents of BC, to access medically, required health services that cannot be obtained on the reserve or in the community of residence.

One criteria of the Medical Transportation Program is that the client **must** submit a signed and/or stamped confirmation of Attendance Form to our office in order to be reimbursed or have future travel arranged. We appreciate and thank you for your cooperation.

Please confirm that the following patient had attended the following appointment at your office:

Patient Name:	Date of Birth:
Date of Appointment:	Time of Appointment:

Physician's Professional Address Stamp:

STAMP HERE

Physician Name: (please print clearly):

Physician Signature:

This form must be **stamped with the physician's address or signed by the physician** confirming your attendance. Please ensure that the date and time of the appointment has also been included on the form. If the section regarding pending appointments is completed by the same doctor, this will eliminate the need to obtain another confirmation of appointment.

PENDING APPOINTMENT (if known)

Date of appointment: _____ Time: _____

Internal Office Use Only

Case #: _____ TA #: _____