

Special Authorization Request For Exception Supply Item

(Allow up to 14 days for delivery)

Please fax completed form to CPS at 1-866-675-0885

Renewal

Initial

DELIVERY:

Delivery to Home

Delivery to Depot

DEPOT CODE:

Other address
if different than
home:

PATIENT INFORMATION	THIS SECTION MUST BE COMPLETED
NAME:	DATE :
PHONE:	ORDERED BY:
BRN:	PROVIDER:

GEOGRAPHY/REGION:

Grey/Bruce Oxford

Perth Elgin

London/Middlesex Huron

Nurse Manager's Name Approving S/A:

Manufacturer: Name of Product:

Product SKU# Size: #Required/Week

Rationale for Use:

Proposed Duration:

Is there a comparable Product(s) in the catalogue? Yes No

Have these Products been trialed? Yes No

LHIN ADMINISTRATOR COMPLETE THIS SECTION

Pre-Authorization Date: Post -Authorization date: E-Code:

Unit Cost: Minimum Ship Pack: Contact Name:

Earliest Date Available:

LHIN MANAGER COMPLETE THIS SECTION: Approved Not Approved

Approved by:

Rationale:

Expiry Date: