



New Patient Reassessment (required after 12 months) Cancellation (patient no longer qualifies) – complete Step 1 and 4 only

## STEP 1 OF 4: PATIENT'S INFORMATION (please print or type)

Last Name <b>Quibell, John Edward Wayne</b>	First Name	Middle Name
Personal 25789512 92030487700 26-AUG-1949 (M) 73 Years ON 2106-891-670	Date of Birth (yyyy / mm / dd) 1 1 1	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
		Telephone Number (include area code) <b>250-618-9006</b>
Mailing <b>459 Kennedy St</b>	City <b>Nanaimo</b>	Province <b>BC</b> Postal Code <b>V9R 2J4</b>

## STEP 2 OF 4: PATIENT'S CONSENT (MANDATORY) - SIGNATURE IS REQUIRED IN OPTION 1 OR 2

## ► Option 1: Patient's Signature (a signature is required here OR In Option 2 below)

I consent to registering for drug coverage and an assessment of medical equipment and supply needs.

► Signature of Patient

Date Signed (yyyy / mm / dd)

OR

► Option 2: Signature of Substitute Decision Maker - Legal Representative or Practitioner (a signature is required here OR In Option 1 above)  
If the patient is unable or unavailable to sign the above section (Option 1)

► Signature of Legal Representative or Practitioner

Date Signed (yyyy / mm / dd)

Telephone Phone Number (include area code)

<b>D. Downe</b>	20230521	250 755 7691
Last Name (print or type) <b>Downe</b>	First Name (print or type) <b>Danielle</b>	Initial <b>A</b> Relationship to Patient <b>Physician</b>

## STEP 3 OF 4: CERTIFICATION BY MEDICAL OR NURSE PRACTITIONER (MUST BE COMPLETED BY PRACTITIONER (MANDATORY))

Primary Diagnosis

**Urothelial cell carcinoma**

Other Diagnosis

 I certify this patient meets all four eligibility criteria as defined below (all four criteria must be met):

- is diagnosed with a life-threatening illness or condition
- has a life expectancy of up to 6 months
- wishes to receive palliative care at home (home as defined on page 1)
- consents to the focus of care being primarily palliative rather than treatment aimed at a cure

Supporting Assessment Using SPCT Tool on page 2 (required)

List at least 2 General Indicators (for example, 1.a., 1.d.):

**1a/1b/1f**

List at least 1 Clinical Indicator (for example, 2.d.(1)):

**2(a) 1**

## STEP 4 OF 4: SIGNATURE OF MEDICAL OR NURSE PRACTITIONER (MANDATORY)

Name and Mailing Address

**D. Downe**

PALLIATIVE  
PALLIATIVE CARE UNIT - NORTH  
100 BUCHERIN CRES.  
NANAIMO BC V9S 2B7

► Signature of Medical or Nurse Practitioner to certify eligibility and to request coverage

**D. Downe**

Date of Registration (yyyy / mm / dd) <b>20230521</b>	Practitioner College ID Number <b>38963</b>
Practitioner Tel Number (with area code) <b>250 755 7691</b>	Practitioner Fax Number <b>250 755 7929</b>

Personal information on this form is collected under the authority of s.22 of the Pharmaceutical Services Act for the operation of the Ministry of Health BC Palliative Care Benefits Program (Plan P). Personal information will be collected for the purpose of determining eligibility for enrolment in Plan P. Personal information will be released to PharmaCare for the provision of drug benefits and, when necessary, to the local Home and Community Care office for the determination of medical supplies and equipment needs. If you or the applicant have questions about the collection of personal information on this form, contact the Health Insurance BC Data Privacy Officer at PO Box 9035 STH Prov Govt, Victoria BC V8V 9E3; or call 604 681-7151 (Vancouver) or 1 800 663-7100 (toll free). This information will be collected, used and disclosed in accordance with the Freedom of Information and Protection of Privacy Act and the Pharmaceutical Services Act.

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In the And SERVICES/What? field, entering "home and community care".

<input checked="" type="checkbox"/> New Patient	<input type="checkbox"/> Discharge from hospital after 11 months	<input type="checkbox"/> Cancellation of the long-term care - complete Step 1 and 4 only
<b>STEP 1: PATIENT'S INFORMATION (please print or type)</b>		
Last Name <b>Tobler</b>	First Name <b>Patrick</b>	Middle Name <b>Murray</b>
Personal Health Number (PHN) <b>918417416128128</b>	Date of Birth (yyyy/mm/dd) <b>1954/04/16</b>	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address <b>306 - 151 Duncan Ave N</b>	City <b>Penticton</b>	Province <b>BC</b> Postal Code <b>V2A 0C1</b>
<b>STEP 2: Q1-Q4: PATIENT'S CONSENT (MANDATORY) - SIGNATURE IS REQUIRED IN OPTION 1</b>		
<input checked="" type="checkbox"/> Option 1: Patient's Signature (Signature is required here OR in Option 2 below) I consent to registration for drug coverage and an assessment of medical equipment and supply needs.		
Signature of Patient <b>Pete Tobler</b>	Date Signed (yyyy/mm/dd) <b>2023/05/19</b>	Telephone Number (Include area code)
OR		
<input checked="" type="checkbox"/> Option 2: Signature of Substitute Decision Maker - Legal Representative or Attorney-in-Fact (Signature is required here OR in Option 1 above) If the patient is unable or unavailable to sign the above section (Option 1)		
Signature of Substitute Decision Maker - Legal Representative or Attorney-in-Fact <b>Patricia Murray</b>	Date Signed (yyyy/mm/dd) <b>2023/05/19</b>	Telephone Number (Include area code)
Last Name (print or type) <b>Murray</b>	First Name (print or type) <b>Patricia</b>	Relationship to Patient <b>Daughter</b>
<b>STEP 3: DECLARATION OF MEDICAL PRACTICE FACILITY (MUST BE COMPLETED BY MEDICAL PRACTICE/CLINIC)</b>		
Facility Name <b>First stage COPD</b>	Facility Address <b>Handicap degeneration.</b>	
<input checked="" type="checkbox"/> I certify this patient meets all four eligibility criteria as defined below (all four criteria must be met):		
• Is diagnosed with a life-threatening illness or condition • Has a life expectancy of up to 4 months • Wishes to receive palliative care at home (home as defined on page 1) • Consents to the focus of care being primarily palliative rather than treatment aimed at a cure		
<b>STEP 4: SIGNATURE OF MEDICAL PRACTICE FACILITY (MANDATORY)</b>		
<b>Medical Practice Facility Name</b> <b>D. Karmagan</b> <b>Po Box 1120</b> <b>Penticton, BC</b> <b>V2A 0J9</b>		
 Date of Registration (yyyy/mm/dd) <b>2023/05/19</b> Physician/Collage ID Number <b>41570</b> Registration or TEL Number / Work telephone <b>250 961 5277</b> Registration Fax Number <b>250-492-9097</b>		

Important Information: All information contained within the patient information form is protected by the Personal Health Information Protection Act of the Province of British Columbia. This personal information will be used to support the patient to be a healthy and active English speaking member of the community. The patient information form is for the provision of long-term care services and will be returned to the long-term care facility or community care facility for the use of medical staff and administrative personnel. Please do not write or mark on this form. You can ask for a copy of the PHIPA from the Ministry of Health at 1-800-663-4333. The Ministry of Health is responsible for the protection of personal health information under the Personal Health Information Protection Act (PHIPA). If you have questions about this form, please contact your local long-term care facility or community care facility.

• Received 2023/05/22 SG

• Approved 2023/05/22 SG

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Enter the fund services "Where?" field, entering "home and community care".

<input checked="" type="checkbox"/> New Patient	<input type="checkbox"/> Reassessment (required after 12 months)	<input type="checkbox"/> Cancellation (patient no longer qualifies) - complete Step 1 and 4 only
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Personal Health Number (PHN)		PETER	Middle Name
905117212014		Date of Birth (yyyy-mm-dd)	
Mailing Address 2351 ROJEM ROAD		Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number (include area code) 250-448-2317
		City KELowna	Province BC
			Postal Code V1V 2G3
STEP 2 OF 4: PATIENT'S CONSENT (MANDATORY) I AGREE TO THE INFORMATION PROVIDED			
Option 1: Patient's Signature (a signature is required here OR In Option 2 below) I consent to registering my			

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Signature of Patient	Statement of medical equipment and supply needs.		
	Date Signed (yyyy / m / dd)		

OR

Option 2: Signature of Substitute Decision Maker

If the patient is unable or unavailable to sign the above section (Option 1 above), A Signature of Legal Representative or Practitioner			
<i>Shirley Green</i> <b>UNRAN</b>	Date Signed (yyyy / mm / dd) <b>2023-05-20</b>	Telephone Phone Number (Include area code) <b>250-448-2317</b>	
Last Name (print or type)	First Name (print or type) <b>SHIRLEY</b>	Initial <b>S</b>	Relationship to Patient <b>SPouse</b>
STEP 3 OF 4: CERTIFICATION BY MEDICAL OR NURSING PRACTITIONER (MUST BE COMPLETED BY PRACTITIONER (MANDATORY))			
Primary Diagnosis		Other Diagnosis	
<b>MULTIPLE MYELOMA</b>			

<p><input checked="" type="checkbox"/> I certify this patient meets all four eligibility criteria as defined below (all four criteria must be met):</p> <ul style="list-style-type: none"> <li>• Is diagnosed with a life-threatening illness or condition</li> <li>• Has a life expectancy of up to 6 months</li> <li>• Wishes to receive palliative care at home (home as defined on page 1)</li> <li>• Consents to the focus of care being primarily palliative rather than treatment aimed at a cure</li> </ul> <p>Reporting Assessment Using SPLIC Tool (change if required)</p> <p>At least 2 General Indicators (for example, i.e., 1.d):</p> <p>1.b., 1.e., 1.g.</p> <p>List at least 1 Clinical Indicator (for example, 2.a (1)).</p> <p>2.a(1), 2.b(2), 2.b(3),</p> <p><b>TIP OF 4: SIGNATURE OF MEDICAL OR NURSE PRACTITIONER/PHARMACIST</b></p> <p>Name and Mailing Address</p> <p>Dr. [REDACTED]</p> <p>b. Signature of Medical or Nurse Practitioner</p>	
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### STOP OF A SIGNAL

DR. MICHELE THOMASSE  
MOUNTAIN VIEW MEDICAL  
CLINIC  
201 - 1789 K.L.O. Rd.  
Kelowna, B.C. V1W 3P3  
Tel: 250-860-8799 Fax: 250-860-8798

b Eligibility of Medical or Nurse Practitioner to certify eligibility and to request coverage.

Date of Registration (mm/yy / mm/dd)	Practitioner College ID Number
2-0-213105120	26014
Practitioner Tel Number (with area code)	Practitioner Fax Number
850-860-6389	850-860-1708

Personal information on this form is collected under the authority of § 87(2) of the Pennsylvania General Act for the Protection of the Privacy of Personal Information. This Act protects individuals who have personal information about them from the loss of privacy and confidentiality. It also protects individuals from the unauthorized disclosure of their personal information. The information will be used and disclosed in accordance with the provisions of the Pennsylvania General Act for the Protection of the Privacy of Personal Information and the Pennsylvania General Act for the Protection of the Privacy of Personal Information.



Ministry of  
Health

PH ENROL RCVD  
PHARMACY CODE:ZWB  
STATUS: done

**PHARMACARE  
PROVIDER ENROLLMENT**

HITH 5432 2021/10/19

Please read the Provider Enrollment Guide prior to completing this form. The Enrollment Guide will help you complete the form correctly and completely.  
Incomplete or Inaccurate forms will be returned unprocessed. You may wish to consult with your legal counsel while preparing this form and associated documentation.

**1. SITE INFORMATION (all fields in this section are mandatory)**

a. Operating Name <b>THE LOCAL PHARMACY</b>	b. Site ID <b>BC00000ZWB</b>		
c. Site Address (street location – do not include P.O. Box) <b>102-225 RUTLAND ROAD SOUTH</b>	City <b>KELOWNA</b>	Prov <b>BC</b>	Postal Code <b>V1X 2Z3</b>
d. Mailing Address (if different from Site Address – can be P.O. Box)	City	Prov	Postal Code
e. Payment Remittance Address (if different from Site Address – can be P.O. Box)	City	Prov	Postal Code
Site Phone Number <b>778 583 5992</b>	Site Fax Number <b>778 583 5994</b>	f. Email Address (site or manager) <b>thelocalpharmacykelowna@gmail.com</b>	
g. Site Manager Name (First/Last – must match college registration ID) <b>SAJAD WAR</b>	Registration ID (5 digits) <b>13148</b>	h. Proposed Opening Date (TBA not acceptable) <b>APRIL 1, 2023</b>	

**2. PROVIDER TYPE (Mandatory - must choose at least one Pharmacy or Device Class)**

a. Pharmacy Class		b. Non-Pharmacy Sub-Class (check all that apply)	
<input checked="" type="checkbox"/> Community Pharmacy OR <input type="checkbox"/> Out-Patient Hospital Pharmacy	<input checked="" type="checkbox"/> Opioid Agonist Treatment Provider	<input type="checkbox"/> Plan B Pharmacy	
<input type="checkbox"/> Devices	<input type="checkbox"/> Compression Garment Provider	<input type="checkbox"/> Orthosis Provider	
	<input type="checkbox"/> Limb Prosthesis Provider	<input type="checkbox"/> Insulin Pump Manufacturer / Distributor	
	<input type="checkbox"/> Breast Prosthesis Provider	<input type="checkbox"/> Other* (ostomy supplies, diabetes supplies)	
	<input type="checkbox"/> Ocular Prosthesis Provider	*DO NOT check box if you are a community pharmacy	

**Pharmacies:** Please include copy of College of Pharmacists of BC (CPBC) licence with application.

**Non-Pharmacy Device Providers:** Please include copy of business licence.

**3. SUB-CLASS ELIGIBILITY**

Please answer all of the following class-specific questions that apply to your site (as indicated in section 2 above).

**IMPORTANT:** if you answer No to any of the questions below, attach a written explanation as to why PharmaCare should consider enrolling you in this sub-class.

**1. Opioid Agonist Treatment**

Have all the pharmacists providing any services at your pharmacy successfully completed the relevant training for the provision of methadone maintenance services? (please see Enrollment Guide for training requirements)

Yes  No

**2. Compression Garment**

Are compression garments being fitted only by persons who have completed training by a manufacturer of compression garments in fitting the type of compression garment being fitted?

Yes  No

**3. Limb Prostheses**

Are limb prostheses being provided only by persons recognized by the Canadian Board for Certification of Prosthetists and Orthotists as qualified to fit limb prostheses?

Yes  No

**4. Breast Prostheses**

Are breast prostheses being fitted only by persons who have completed training by a breast prosthesis manufacturer in fitting breast prostheses?

Yes  No

**5. Ocular Prostheses**

Are ocular prostheses being provided only by persons recognized by the National Examining Board of Ocularists as qualified to fit ocular prostheses?

Yes  No

**6. Orthoses**

Are orthoses being provided only by persons recognized by the Canadian Board for Certification of Prosthetists and Orthotists as qualified to fit orthoses?

Yes  No

**A. SOFTWARE VENDOR**

If you use PharmaNet to submit claims, please indicate the type of software used.

Vendor Name	Version
ARI (APPLIED ROBOTICS INC.)	VERSION 4

**5. OWNER INFORMATION** (all fields in this section are mandatory)

- a. Type of Ownership       Sole Proprietorship       Partnership       Corporation       Health Authority       Other - specify:

b. Registered or Legal Name of Sole Proprietor, Partnership, Corporation or Health Authority

SW PHARMACY LTD.

c. Mailing Address <b>102-225 RUTLAND ROAD SOUTH</b>		City <b>KELOWNA</b>	Prov <b>BC</b>	Postal Code <b>V1X 2Z3</b>
Phone Number <b>778 583 5992</b>	Fax Number <b>778 583 5994</b>	Email Address <b>sajadadmin@gmail.com</b>		

**4. For business types other than sole proprietorship, please check type below and include the relevant information, as applicable:**

*(If you are unsure of what constitutes relevant information, consult your legal counsel.)*

- (If you are unsure of what constitutes relevant information, consult your legal counsel.)

  - Partnership: Please provide the list of partners and contact information on **Schedule A: Owner Details**.
  - B.C. incorporated corporations that are not publicly traded (including subsidiary corporations): Provide a copy of the BC Company Summary, the shareholder's register and any relevant provisions of any shareholder agreements with respect to the operation of the site.
  - B.C. incorporated corporations that are publicly traded: Provide a copy of the BC Company Summary.
  - Federally incorporated corporations that are not publicly traded: Provide the names and contact information of all officers and directors on **Schedule A: Owner Details** and provide the shareholder's register and any relevant provisions of any shareholder agreements with respect to the operation of the site.
  - Federally incorporated corporations that are publicly traded: Provide the names and contact information of all officers and directors on **Schedule A: Owner Details**.
  - All corporations: a copy of any powers of attorney in respect of the corporation (showing the names and contact information of all persons who may exercise a power of attorney).

## **6. ADDITIONAL SITES**

Please identify any owner or the manager of this site who is currently an owner or manager of any other site.

Each owner or manager named above must complete Schedule B: Additional Sites.

Note: As defined in the **Enrolment Guide**, in the case of a corporation, owner includes the corporation, the directors, the officers and, in the case of a corporation that is not publicly traded, the shareholders. In the case of a subsidiary corporation that is not publicly traded and that has a parent corporation that is not publicly traded, owner includes the parent corporation and the directors, officers and shareholders of the parent corporation.

### **7 ADDITIONAL INFORMATION (all questions in this section are mandatory)**

Please read the following and answer the following questions.

Please carefully review and answer the following questions.

Note: When a term appears in **boldface**, it is a defined term with the meaning contained in Schedule C.

**IMPORTANT:** If you answer Yes to

- Financials and Disciplinary History**

  1. a. Is any owner or the manager of this site currently required to pay any monies to the B.C. government or a public insurer as a result of a relevant audit of any site?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  - b. Is any entity (e.g., corporation, person) currently required to pay any monies to the B.C. government or a public insurer as a result of a relevant audit of any other site that was, during the audit period, owned or managed by any owner or the manager of this site?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  2. a. Has any owner or the manager of this site ever been the subject of an order or a conviction for an information or billing contravention?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  - b. Has any owner or the manager of this site ever been the owner or manager of any other site at the time that an information or billing contravention occurred for which an order or conviction was issued with respect to that other site?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  3. a. Are the billing privileges of any owner or the manager of this site currently suspended?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  - b. Is any owner or the manager of this site currently an owner or manager of any other site in respect of which a person's billing privileges are suspended?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  4. a. Has any owner or the manager of this site ever had their billing privileges cancelled?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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  - b. Was any owner or the manager of this site the owner or manager of any other site at the time that an incident occurred in relation to that site resulting in the cancellation of billing privileges for that site?
 

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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