



Ontario Health

Cancer Care Ontario

Special Access Program Form – Rectal Spacers Reimbursement Form for Prostate Cancer Patients

Please upload to assigned MFT folder, **DO NOT EMAIL**

MFT\Radiation Treatment Program\Cancer Centre Name\Rectal Spacer SAP

Ontario Health (Cancer Care Ontario) collects and uses information on this form to make eligibility recommendations; and for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of the allocation of resources to or planning for all or part to the health system, including the delivery of services, pursuant to section 45 of the Personal Health Information Protection Act, 2004. As part of the evaluation and reimbursement process, it may be necessary for Ontario Health (Cancer Care Ontario) to disclose or share the patient's personal health information (PHI) to other administrative programs for health services and insured benefits at the Ministry of Health or at Ontario Health (Cancer Care Ontario).

Patient Information	
Patient Name: <i>(Surname, Given Name)</i>	
Date of Birth: <i>(Day/Month/Year)</i>	
OHIP #:	
MRN #:	
Physician requesting SAP:	
Referring Centre <i>(please select)</i>:	<input type="checkbox"/> London Regional Cancer Program <input type="checkbox"/> The Ottawa Hospital Cancer Centre <input type="checkbox"/> Odette Cancer Centre <input type="checkbox"/> Windsor Regional Cancer Centre <input type="checkbox"/> Princess Margaret Cancer Centre <input type="checkbox"/> R.S. McLaughlin Durham Regional Cancer Centre <input type="checkbox"/> Northeast Cancer Centre (Health Sciences North) <input type="checkbox"/> Grand River Regional Cancer Centre <input type="checkbox"/> Juravinski Cancer Centre <input type="checkbox"/> Carlo Fidani Regional Cancer Centre <input type="checkbox"/> Thunder Bay Regional Health Sciences Centre <input type="checkbox"/> Stronach Regional Cancer Centre at Southlake <input type="checkbox"/> Cancer Centre of Southeastern Ontario <input type="checkbox"/> Simcoe Muskoka Regional Cancer Centre <input type="checkbox"/> Walker Family Cancer Centre <input type="checkbox"/> Sault Area Hospital – Algoma District Cancer
Baseline Information	
Clinical Stage (T, N, M):	
PSA:	
Gleason Score:	



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Other information	
Reasons for Special Access request: <i>(Please select all that apply from list)</i>	<input type="checkbox"/> Rectal dose exceeded <input type="checkbox"/> Dose escalation beyond usual SOC <input type="checkbox"/> Other (please explain):
Supporting Clinical Information:	
Attending Radiation Oncologist Name:	
Email of Attending Radiation Oncologist:	
Today's Date (Day/Month/Year):	Click or tap to enter a date.
For Completion by OH-CCO ONLY: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved Date: Click or tap to enter a date. <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>X</p> </div> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 5px;"> <p>Provincial Head, Radiation Treatment</p> </div>	

By signing this form, I confirm that the patient named above, or relevant substitute decision-maker where applicable, has been informed by the Applicant that the patient's Personal Health Information (PHI), as such term is defined in the *Personal Health Information Protection Act, 2004*, as amended, will be disclosed to and used by Ontario Health (Cancer Care Ontario), in order to determine the patient's eligibility to receive funding for the above-mentioned requested service pursuant to the criteria as set out in the Special Access Program. Ontario Health (Cancer Care Ontario) collects and uses information on this form to make eligibility recommendations pursuant to section 39(1)(a) of PHIPA; and for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of the allocation of resources to or planning for all or part of the health system, including the delivery of services, pursuant to section 45 of the Personal Health Information Protection Act, 2004. I confirm that the patient, or relevant substitute decision-maker where applicable, has provided his/her express consent for the disclosure and use of their PHI in accordance with the above stated purpose.