# Manitoba Health

## Application to Manitoba Hepatitis C Assistance Program (MHCAP) - Physician Form

The Government of Manitoba is introducing a program to provide financial assistance to persons infected with Hepatitis C prior to January 1, 1986 or between July 2, 1990 to September 28, 1998. The following information is required to assist the applicant in obtaining assistance under the program. The applicant has provided Manitoba Health and anyone acting on its behalf for the purpose of administering the Manitoba Hepatitis C Assistance Program, with the authority to collect this information from you.

Send completed form to: Manitoba Health MHCAP 4036 - 300 Carlton Street Winnipeg, MB R3B 3M9

### Applicant's Authorization to Disclose Information

I hereby authorize the physician named on this form to disclose to Manitoba Health, including the employees, representatives and agents of Manitoba Health for the purpose of administering the Manitoba Hepatitis C Assistance Program, any personal health information in his or her possession regarding myself and to provide to Manitoba Health, or anyone acting on its behalf for the purpose of administering the Program, as requested in writing by Manitoba Health with copies of any records in his or her possession regarding myself, and for so doing this is good and sufficient authority.

Signature of applicant) (Date) (day/month/year)

### 1. Applicant's Information (to be completed by applicant)

Last Name | First Name | Middle Initial | Date of birth *(day/month/year)*

Address | City | Province | Postal Code

Telephone no. (home) ( ) Telephone no. (business) ( ) *(optional)*

### 2. Physician Information (to be completed by physician)

Physician's Name | MCPS Registration No. | Specialty

Business address | Telephone No. ( )

### 3. Medical Information (to be completed by physician)

How long have you been the applicant's physician? Years

Is applicant diagnosed with Hepatitis C (HCV)? ☐ Yes ☐ No If yes, attach a copy of laboratory test (required)

Did you make the diagnosis? ☐ Yes ☐ No

When was applicant diagnosed? *(day/month/year)*

Did applicant receive a transfusion in Manitoba during any or all of the following time period (s)?

☐ on or before December 31, 1985 ☐ Jan. 1 , 1986 - July 1, 1990 ☐ July 2, 1990 - Sept. 28, 1998. ☐ Don't Know

Reason for Transfusion

Name of hospital(s) in Manitoba where transfusion(s) occurred:

| | | | |
|---|---|---|---|
| Name of hospital (1) | Date of transfusion | City | Province |
| Name of hospital (2) | Date of transfusion | City | Province |
| Name of hospital (3) | Date of transfusion | City | Province |

Is applicant a hemophiliac? If **Yes**, did applicant receive blood products in Manitoba during any or all of the following time period(s)?

☐ Yes ☐ No ☐ on or before December 31, 1985 ☐ Jan. 1 , 1986 - July 1, 1990 ☐ July 2, 1990 - Sept. 28, 1998.

Do you have knowledge of any other risk factors for HCV infection for this applicant? (e.g. *history* of *intravenous drug use*, *occupational exposure*, *tattoos)*
Yes ☐ *(specify)* ☐ No ☐ Unknown

Explain

**Collection of the personal information on this form is to determine eligibility for the Manitoba Hepatitis C Assistance Program. The authority for the collection and use of this information is the Personal Health Information Act S.M. 1997, c51, as 13(7) and 27. For Information about collection practices, please contact MHCAP, 4036 - 300 Carlton Street, Winnipeg Mb R3B 3M9, Tel. No. (toll free) 1-866–357-0196, in Winnipeg call 788-6339.**

Physician signature | Date *(daylmonthlyear)*

White - Manitoba Health; Canary - Hospital; pink-Applicant

*(Disponible en francais)*