Home Oxygen Concentrator Program
Request for Removal of Service

Date ____ / _____ / _____

Client Information

First Name: _____ Last Name: _____
Date of Birth: _____ Phone Number: _____
Address: _____ Postal Code: _____
_____
MHSC Number: _____ PHIN Number: _____
Treaty Number: _____

Removal Information

Please be advised that the equipment and suppies that were installed in the client's home listed above are no longer required as a result of:

_____ clinical condition improved and no longer requires oxygen.
_____ client is deceased.
_____ client is no longer in Southern Health-Sante Sud region.
_____ other _____
_____

To arrange a convenient time to remove this equipment, please contact the following:

Name _____ Phone Number _____
Relationship to Client _____
Comments (e.g. Special considerations with respect to timing of removal) _____
_____
_____
_____
_____

Upon completion of removal, please forward a copy of your "Equipment Removal Report" to my attention.

Name _____ Position _____

Signature _____ Fax Number _____