Ontario Ministry of Health

Oral and Maxillofacial Rehabilitation Program (OMRP) Application

Application Instruction

The Oral and Maxillofacial Rehabilitation Program (OMRP) is funded by the Ministry of Health in support of patients who require implants to retain a prosthetic device in order to restore oral function when no other treatment alternative exists. To be eligible for this program, an individual must have their removable prosthetic device funded through the Assistive Devices Program (ADP). This program does not fund routine dental care or dental implants used to retain fixed devices or dentures.

Eligibility Requirements:

In order to be eligible for the OMRP, applicants must be in possession of a valid Ontario Health Card Number and be 18 years of age or older. Those below this age limit can apply for funded services through the Cleft Lip and Palate / Craniofacial Program.

In addition, a patient must be eligible for an Assistive Devices Program (ADP) maxillofacial intraoral prosthesis and in the clinical opinion of an ADP Authorizer and Oral and Maxillofacial Surgeon:

- the severity of the patient's condition is such the patient is or will be unable to retain their maxillofacial intraoral prosthesis,
- the patient is a suitable candidate for dental implant surgery, and
- no other treatment alternative exists and an implant-supported maxillofacial intraoral prosthesis is required as a substitute for partially or totally absent tissue and to restore function of the oral complex.

Notes:

1. “Maxillofacial intraoral prosthesis” includes only those prostheses currently listed in the Assistive Devices Program (ADP) Maxillofacial Intraoral Prosthesis Product Manual.
   http://www.health.gov.on.ca/en/pro/programs/adp/product_manuals/product_manuals.aspx
2. For clarity, tissue is defined as both hard and soft tissue, including bone, gingiva and teeth.
3. “To restore function of the oral complex” includes chewing, swallowing and speaking.
4. All prostheses will be funded through ADP following the policies and processes outlined in ADP’s Maxillofacial Intraoral Prosthesis Policy and Administration Manual. This includes the sole use of Authorizers and Vendors registered with ADP and adherence to ADP’s funding policies. Patients who do not meet ADP’s eligibility requirements, who require a device not listed in the ADP’s product manual (e.g. fixed devices such as a fixed crown or bridge), or whose Maxillofacial Intraoral Prosthesis is fabricated by a non-ADP registered supplier, will not be eligible to receive funding through the OMRP.

Instructions for Referring Provider:

1. Complete sections 1 - 3 only and submit to one of the sites listed below. The remainder of the form will be completed by the clinicians participating in this program.
2. Print clearly. Incomplete or illegible forms will be returned.
3. Patients who will be eligible for this program will typically have had a major jaw reconstruction following a condition affecting the oral complex (such as a major avulsive traumatic injury or tumour ablation surgery requiring reconstruction) and subsequently require implants to retain a removable prosthetic device to replace missing tissue, teeth and bone. If you believe a patient will not meet the eligibility criteria, a referral should not be made.
4. In general, patients should be cancer free for a period of one year prior to a referral for this program.
5. Provide as much detailed information as possible, including associated photographs and diagnostic images.

OMRP Service Delivery Sites:

☐ Sunnybrook Health Sciences Centre
Department of Dentistry
2075 Bayview Avenue
Suite H126
Toronto ON M4N 3M5
Tel: 416 480-4436
Fax: 416 480-5757

☐ London Health Science Centre
Oral and Maxillofacial Surgery
339 Windermere Road
University Hospital, Rm B3-300
London ON N6A 5A5
Tel: 519 663-3451
Fax: 519 663-3004

☐ Ottawa Civic Hospital
Dental Clinic
1053 Carling Avenue
Ottawa ON K1Y 4E9
Tel: 613 798-5555 ext. 14084
Fax: 613 761-5134

☐ University Health Network/
Mount Sinai Hospital
c/o University Health Network
Dept of Dentistry, Maxillofacial
and Ocular Prosthetics
610 University Ave., Rm 2-933
Toronto ON M5G 2M9
Tel: 416 946-2198
Fax: 416 946-6576

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Application for Oral and Maxillofacial Rehabilitation Program (OMRP)

Section 1 - Patient Information *(completed by Referring Provider)*

Last Name	First Name	Middle Initial

Date of Birth *(yyyy/mm/dd)*	Sex ☐ M ☐ F	Health Card Number	Version Code

Mailing Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code	Telephone Number

Section 2 - Referring Provider Information

Last Name	First Name	Middle Initial

Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number	Fax Number	Email Address

Section 3 - Medical Information *(completed by Referring Provider)*

Diagnosis

☐ Tumour ☐ Trauma ☐ Acquired Deformity ☐ Congenital Abnormality

Specific Diagnosis

Has the patient had major jaw reconstruction? ☐ No ☐ Yes *(provide details ▼)*

Specify date, location and description of previous reconstructive surgery

Current Maxillofacial Intraoral Prosthesis, *if applicable*

☐ Mandible *(specify prosthesis type)* _____

☐ Maxilla *(specify prosthesis type)* _____

	Available		Attached	
	Yes	No	Yes	No
Diagnostic Reports and Images	☐	☐	☐	☐
Previous Operative Reports	☐	☐	☐	☐
Relevant Investigations and / or Lab Values	☐	☐	☐	☐

Section 4 - Eligibility *(completed by ADP Authorizer)*

Patient Last Name	Patient First Name	Patient Middle Initial

Is the patient 18 years or older? ☐ No ☐ Yes

Does the patient have a valid Health Card Number? ☐ No ☐ Yes

Is the patient eligible for an ADP Maxillofacial Intraoral prosthesis? ☐ No ☐ Yes

Can the patient retain prosthesis without implants? ☐ No ☐ Yes

Is the patient a suitable candidate for dental implants? ☐ No ☐ Yes

Type of prosthesis required:

☐ Mandible *(specify prosthesis type)* _____

☐ Maxilla *(specify prosthesis type)* _____

Patient Case Number *(assign to eligible patients only and record on ADP-funding application)*

Site Initials - Fiscal Year - Patient Number

Has ADP approval for funding been received by ADP Vendor?

☐ Yes ☐ No

Name of ADP Authorizer	Name of Oral Maxillofacial Surgeon

Section 5 - Confirmation of Eligibility *(completed by Program Lead)*

Instructions: To be signed by the Program Lead only once ADP approval given to ADP Vendor

☐ I confirm that the patient has undergone an eligibility assessment by an ADP Authorizer and Oral and Maxillofacial Surgeon and that he/she meets the eligibility requirements for the Oral and Maxillofacial Rehabilitation Program.

☐ Yes ☐ No *(provide details ▼)*

☐ For patients who choose NOT to participate in the program, I confirm that despite being eligible for the program and being fully informed of the funding available to support his/her dental rehabilitation needs, the patient is choosing not to participate in the OMRP. The patient has been informed that if he/she pays privately, he/she will not be reimbursed by the hospital or the Province at a later date for these services.

Name of Program Lead	Signature of Program Lead

Section 6 - Request for Review *(completed by Program Lead only on Request for Review of Eligibility)*

Name of ADP Authorizer conducting second review of eligibility

Last Name	First Name

Result of Review: ☐ Ineligible ☐ Meets eligibility criteria *(go to section 7)*

If patient was determined ineligible for the OMRP following a second review and requested a third review, results of committee review:

☐ Patient remains ineligible ☐ Patient meets eligibility criteria *(go to section 7)*

Name of Program Lead	Signature of Program Lead

Section 7 - Eligible on Second / Third Review

Patient Last Name	Patient First Name	Patient Middle Initial

If eligible on second / third review, type of prosthesis required:

☐ Mandible *(specify prosthesis type)* _____

☐ Maxilla *(specify prosthesis type)* _____

Patient Case Number *(assign to eligible patients only and record on ADP-funding application)*

Site Initials - Fiscal Year - Patient Number

Has ADP approval for funding been received by ADP Vendor?

☐ Yes ☐ No

Name of ADP Authorizer

To be signed by Program Lead only once ADP approval given to ADP Vendor.

I confirm that the patient has undergone an eligibility assessment by an ADP Authorizer and Oral and Maxillofacial Surgeon and that he/she meets the eligibility requirements for the Oral and Maxillofacial Rehabilitation Program.

Signature of Program Lead

Date *(yyyy/mm/dd)*

Section 8 - Discharge

Date of Discharge from the OMRP	

Reason for Discharge

☐ Treatment completed

☐ Patient has withdrawn from program *(specify reason below ▼)*

Reason for withdrawal

Print Form

Clear Form