

CMEDS EQUIPMENT LOAN REQUEST

(To be completed by the client's therapist)

*Mandatory Fields

Equipment Loan Request Form Submission Date: ____

CLIENT INICODMATION

*Name: *DOB (MM/DD/YYYY):					
	*Width: *Depth:		*Leg Length:		*Weight:
*Address:	width.	*City:	*Province:	9011	*Postal Code:
PARENT/CAREGIVER INFORMATION					
Name:	Phone):		Email:	
THERAPIST INFORMATION					
Name: Facility:					
Email:	Phone):		Fax:	
☐ Therapist has discussed with the family to allow the release of their contact and private information for HME to contact them ☐ Therapist would like to be present for delivery					
DELIVERY					
Within Lower Mainland Deliver to Home or Facility (specify address): Family pick up at HME Richmond #130 - 4011 Viking Way Richmond, BC V6V 2K9 Outside of Lower Mainland (If equipment needs setup or install, client's family must courier to one of the following medical suppliers for setup below) Courier to Home or Facility (specify address): Courier to local Medical Supplier (select 1 supplier below) HME Home Health Victoria Verron Motion Kelowna Motion Nanaimo National Seating & Mobility Canada Relowna Motion Relo					
□ Penticton Motion □ Vernon National Seating & Mobility Canada					
EQUIPMENT					
If dimensions of seat width and depth are provided, CMEDS will build equipment to those specifications.					
MANUA	L WHEELCHAIR		POWER WHEELCHAIR		
Seat Width:	Seat Depth:		Seat Width:		Seat Depth:
Wheelchair Type:		1 Transport	Tilt: With Tilt Without Tilt		
☐ Folding ☐ Rigid ☐ Tilt ☐ Hemi Height ☐ Transport		<u> </u>	Drive Type: ☐ Mid-Wheel ☐ Rear Wheel		
Seat to Floor (no cushion): Backrest Height:		Joystick: ☐ Left ☐ Right ☐ Attendant			
Headrest:	Footrests:		Seat to Floor (no cu	ıshion):	Backrest Height:
Seatbelt Type: Stand			Headrest:		Footrests:
Transit Option: Yes		toller Handle	Seatbelt Type: [Standard	☐ Other:
Anti Tippers Laptr			Transit Option:	Yes	□ No
Cushion Type:	Size:		Anti Tippers	Laptray	☐ Calf Pad
Backrest Type:	Size:		Cushion Type:		Size:
Notes:			Backrest Type:		Size:
			Notes:		



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LIFT SY	'STEMS	BEDS & MATTRESSES			
☐ Floor to Ceiling Pole Ceiling Height:	☐ With Superbar	☐ Hospital Bed ☐ Manual ☐ Electric ☐ Trendelendburg			
☐ Floor Lift	☐ Free Standling Lift	☐ Bed Rails			
☐ Sit to Stand Lift	☐ Tension Mounted Lift	☐ Half Rails ☐ Full Rails ☐ Bed Assist Rail			
☐ Portable Motor only	I rension Mounted Lift	☐ Mattress			
		Foam:			
│	Small	Low Air Loss: Alternating Pressure:			
Sling Type:		ROHO Mattress Section (1) amount: Leveling Pad (1) amount: Notes:			
*Note: CMEDS does not recycle or have a	ccess to fixed ceiling tracks or fixed motors				
Notes:					
BATHROOM	EQUIPMENT	WALKING AIDS			
☐ Raised Toilet Seat		☐ Walker			
2" 4" With Arı	ms	☐ Stationary ☐ 2 Wheels ☐ 4 Wheels			
Commode	STF:	Anterior Posterior Other: Handle Height: Size:			
☐ Wheeled ☐ Stationary	☐ Tilt ☐ Drop Arm	Additional Supports Needed:			
☐ Shower Commode ☐ With Tilt ☐ Without Tilt		Cane			
☐ Pediatric Toilet Support		Type: Size:			
Type:	Size:	Notes:			
☐ Bathtub Transfer Bench☐ Padded☐ Unpadded	☐ Arm on Left ☐ Arm on Right	ALTERNATIVE POSITIONING CHAIR			
☐ Bathtub Chair		Positioning Chair Chair Width: Chair Depth:			
☐ With Back ☐ Without Back		Chair Width: Chair Depth:			
☐ Small ☐ Medium ☐ Large		Notes:			
☐ Toilet Safety Frame ☐ Bath Board ☐ Bath Lift ☐ Tub Grip:		STROLLERS, SCOOTERS, STANDERS			
Notes:		☐ Stroller			
		Type: Size:			
	QUIPMENT	Scooter Make/Model: Size:			
Ball Size:	Peanut Ball Size:	☐ Stander			
☐ Wedge Size:	Roll Size:	☐ Prone ☐ Supine ☐ Sit to Stand			
│	Thickness:	Size: Accessories/Supports:			
Notes:		Notes:			
COMMENTS, SPECIAL INSTRUCTIONS, OR ANY EQUIPMENT NOT LISTED:					

Children who receive palliative care at home, have been diagnosed with a life-threatening illness or condition (as indicated by the child's physician on the At Home Program Application form), and have a life expectancy of up to six months, are eligible for both AHP Respite and AHP Medical Benefits without an AHP assessment. All Requests for Equipment will Only be Held for 2 Weeks.

*Therapist Signature: _____