



CMEDS EQUIPMENT LOAN REQUEST

(To be completed by either the client's therapist/caregiver)

Equipment Loan Request Form Submission Date: _____

CLIENT INFORMATION

Name:		DOB (MM/DD/YYYY):		<input type="checkbox"/> Palliative
Height:	Width:	Depth:	Leg Length:	Weight:
Address:		City:	Province:	Postal Code:
Phone:				

PARENT/CAREGIVER INFORMATION

Name:	Phone:	Email:
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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)
- | | | |
|--|--|---|
| <input type="checkbox"/> HME Victoria | <input type="checkbox"/> Castlegar Kootenay Columbia Home Medical Equipment | <input type="checkbox"/> Cranbrook Kootenay Columbia Home Medical Equipment |
| <input type="checkbox"/> Courtenay Island Mediquip | <input type="checkbox"/> Kamloops National Seating & Mobility Canada | <input type="checkbox"/> Kelowna National Seating & Mobility Canada |
| <input type="checkbox"/> Kelowna Motion | <input type="checkbox"/> Nanaimo National Seating & Mobility Canada (Advanced) | <input type="checkbox"/> Prince George National Seating & Mobility Canada |
| <input type="checkbox"/> Penticton Motion | <input type="checkbox"/> Vernon Motion | <input type="checkbox"/> Vernon National Seating & Mobility Canada |

EQUIPMENT

If dimensions of seat width and depth are provided, CMEDS will build equipment to those specifications.

MANUAL WHEELCHAIR

Seat Width:	Seat Depth:
Wheelchair Type: <input type="checkbox"/> Folding <input type="checkbox"/> Rigid <input type="checkbox"/> Tilt <input type="checkbox"/> Hemi Height <input type="checkbox"/> Transport	
Seat to Floor (no cushion):	Backrest Height:
Headrest:	Footrests:
Seatbelt Type: <input type="checkbox"/> Standard <input type="checkbox"/> Other: _____	
Transit Option: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Stoller Handle	
<input type="checkbox"/> Anti Tippers <input type="checkbox"/> Laptray <input type="checkbox"/> Calf Pad	
Cushion Type:	Size:
Backrest Type:	Size:
Notes:	

POWER WHEELCHAIR

Seat Width:	Seat Depth:
Tilt: <input type="checkbox"/> With Tilt <input type="checkbox"/> Without Tilt	
Drive Type: <input type="checkbox"/> Mid-Wheel <input type="checkbox"/> Rear Wheel	
Joystick: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Attendant	
Seat to Floor (no cushion):	Backrest Height:
Headrest:	Footrests:
Seatbelt Type: <input type="checkbox"/> Standard <input type="checkbox"/> Other: _____	
Transit Option: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Anti Tippers <input type="checkbox"/> Laptray <input type="checkbox"/> Calf Pad	
Cushion Type:	Size:
Backrest Type:	Size:
Notes:	

Ministry of Children and Family Development

Email: MCF.MedicalBenefitsProgram@gov.bc.ca

Toll-Free Phone: 1 (888) 613-3232

Fax: 1 (250) 356-2159

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LIFT SYSTEMS	
<input type="checkbox"/> Floor to Ceiling Pole Ceiling Height: _____ <input type="checkbox"/> With Superbar	
<input type="checkbox"/> Floor Lift	<input type="checkbox"/> Free Standing Lift
<input type="checkbox"/> Sit to Stand Lift	<input type="checkbox"/> Tension Mounted Lift
<input type="checkbox"/> Portable Motor only	
<input type="checkbox"/> Sling <input type="checkbox"/> Child <input type="checkbox"/> Junior <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large Sling Type: _____	
<small>*Note: CMEDS does not recycle or have access to fixed ceiling tracks or fixed motors</small>	
Notes:	

BEDS & MATTRESSES	
<input type="checkbox"/> Hospital Bed <input type="checkbox"/> Manual <input type="checkbox"/> Electric <input type="checkbox"/> Trendelenburg	
<input type="checkbox"/> Bed Rails <input type="checkbox"/> Half Rails <input type="checkbox"/> Full Rails <input type="checkbox"/> Bed Assist Rail	
<input type="checkbox"/> Mattress <input type="checkbox"/> Foam: _____ <input type="checkbox"/> Low Air Loss: _____ <input type="checkbox"/> Alternating Pressure: _____ <input type="checkbox"/> ROHO Mattress Section (1) amount: _____ <input type="checkbox"/> Leveling Pad (1) amount: _____	
Notes:	

BATHROOM EQUIPMENT	
<input type="checkbox"/> Raised Toilet Seat <input type="checkbox"/> 2" <input type="checkbox"/> 4" <input type="checkbox"/> With Arms	
<input type="checkbox"/> Commode STF: _____ <input type="checkbox"/> Wheeled <input type="checkbox"/> Stationary <input type="checkbox"/> Tilt <input type="checkbox"/> Drop Arm	
<input type="checkbox"/> Shower Commode <input type="checkbox"/> With Tilt <input type="checkbox"/> Without Tilt	
<input type="checkbox"/> Pediatric Toilet Support Type: _____ Size: _____	
<input type="checkbox"/> Bathtub Transfer Bench <input type="checkbox"/> Padded <input type="checkbox"/> Unpadded <input type="checkbox"/> Arm on Left <input type="checkbox"/> Arm on Right	
<input type="checkbox"/> Bathtub Chair <input type="checkbox"/> With Back <input type="checkbox"/> Without Back <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large	
<input type="checkbox"/> Toilet Safety Frame <input type="checkbox"/> Bath Board <input type="checkbox"/> Bath Lift <input type="checkbox"/> Tub Grip: _____	
Notes:	

WALKING AIDS	
<input type="checkbox"/> Walker <input type="checkbox"/> Stationary <input type="checkbox"/> 2 Wheels <input type="checkbox"/> 4 Wheels <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Other: _____ Handle Height: _____ Size: _____ Additional Supports Needed: _____	
<input type="checkbox"/> Cane Type: _____ Handle Height: _____ Size: _____	
Notes:	

ALTERNATIVE POSITIONING CHAIR	
<input type="checkbox"/> Positioning Chair Chair Width: _____ Chair Depth: _____ Chair Height: _____ <input type="checkbox"/> Footrest needed	
Notes:	

STROLLERS, SCOOTERS, STANDERS	
<input type="checkbox"/> Stroller Type: _____ Size: _____	
<input type="checkbox"/> Scooter Make/Model: _____ Size: _____	
<input type="checkbox"/> Stander <input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> Sit to Stand Size: _____ Accessories/Supports: _____	
Notes:	

THERAPY EQUIPMENT	
<input type="checkbox"/> Ball Size: _____	<input type="checkbox"/> Peanut Ball Size: _____
<input type="checkbox"/> Wedge Size: _____	<input type="checkbox"/> Roll Size: _____
<input type="checkbox"/> Mat Length: _____ Width: _____ Thickness: _____	
Notes:	

COMMENTS, SPECIAL INSTRUCTIONS, OR ANY EQUIPMENT NOT LISTED:	