

Childrens Medical Equipment Distribution Service

Date: _____ Date Needed: _____ Type of Request: Short-Term (3 months or less) Long-Term Trial

Client Info:

Client name:	Phone:	Height/Weight:
Address:	City:	Parent/Guardian:

Therapist Info:

Name:	Facility:	Phone:
Email:	Fax:	

Therapist has discussed with the family to allow the release of their contact and private information to HME in order to contact them

Please check if Therapist would like to be present for delivery

Delivery Information:

If client in lower mainland:

Deliver to Home/Facility (specify address): _____

Client family to pick-up at HME Mobility: #130 4011 Viking Way, Richmond

If client is outside of lower mainland: (please note if equipment needs setup/install, must courier to local medical supplier for setup below)

Courier to Home/Facility (specify address): _____

Courier to Local Medical Supplier:

<input type="checkbox"/> HME Mobility Victoria	<input type="checkbox"/> PG Surg Med- Vernon	<input type="checkbox"/> North Coast Home Medical Equipment- Terrace	<input type="checkbox"/> Advanced Mobility Nanaimo
<input type="checkbox"/> Creative Mobility Vernon	<input type="checkbox"/> PG Surg Med- Prince George	<input type="checkbox"/> Kootenay Columbia Home Medical Equipment- Cranbrook	<input type="checkbox"/> Island Mediquip Courtenay
<input type="checkbox"/> Creative Mobility Penticton	<input type="checkbox"/> PG Surg Med- Kamloops	<input type="checkbox"/> Kootenay Columbia Home Medical Equipment- Castlegar	
<input type="checkbox"/> Creative Mobility Kelowna			

Equipment

<input type="checkbox"/> Manual Wheelchair Seat Width: _____ Seat Depth: _____ 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"/> Anti Tippers <input type="checkbox"/> Laptray <input type="checkbox"/> Calf Pad <input type="checkbox"/> Stroller Handle <input type="checkbox"/> Cushion Type: _____ Size: _____ <input type="checkbox"/> Backrest Type: _____ Size: _____ Notes: _____ _____ _____	<input type="checkbox"/> Power Wheelchair Seat Width: _____ Seat Depth: _____ <input type="checkbox"/> With Tilt <input type="checkbox"/> Without Tilt Drive: <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 <input type="checkbox"/> Stroller Handle <input type="checkbox"/> Cushion Type: _____ Size: _____ <input type="checkbox"/> Backrest Type: _____ Size: _____ Notes: _____ _____ _____
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Alternative Positioning Chair

<input type="checkbox"/> Chair Width: _____ Depth: _____ Height: _____ <input type="checkbox"/> Footrest needed <input type="checkbox"/> Overbed Table Notes: _____	<input type="checkbox"/> Scooter Make/Model: _____ Size: _____ Notes: _____ _____
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Bathroom Equipment:		Walking Aids	
<input type="checkbox"/> Raised Toilet Seat: <input type="checkbox"/> 2" <input type="checkbox"/> 4" <input type="checkbox"/> with arms		<input type="checkbox"/> Walker <input type="checkbox"/> stationary <input type="checkbox"/> 2 wheels <input type="checkbox"/> 4 wheels	
<input type="checkbox"/> Commode: <input type="checkbox"/> wheeled <input type="checkbox"/> stationary <input type="checkbox"/> tilt <input type="checkbox"/> drop arm STF:		<input type="checkbox"/> Anterior <input type="checkbox"/> Posterior Other:	
<input type="checkbox"/> Shower commode: <input type="checkbox"/> no tilt <input type="checkbox"/> with tilt		Handle Height:	
<input type="checkbox"/> Paediatric Toilet Support Type: _____ Size: _____		Additional supports needed:	
<input type="checkbox"/> Toilet Safety Frame	<input type="checkbox"/> Bath Board	<input type="checkbox"/> Cane	
<input type="checkbox"/> Tub Grip Model:	<input type="checkbox"/> Bath Lift	Type:	
<input type="checkbox"/> Bath Tub Transfer Bench: <input type="checkbox"/> Padded <input type="checkbox"/> Unpadded	Arm on: <input type="checkbox"/> left <input type="checkbox"/> right	Handle Height:	
<input type="checkbox"/> Bath Chair: <input type="checkbox"/> with back <input type="checkbox"/> no back		Notes:	
Notes:		Beds/Mattresses	
		<input type="checkbox"/> Hospital Bed: <input type="checkbox"/> Manual <input type="checkbox"/> Electric <input type="checkbox"/> Trendelenberg <input type="checkbox"/> Enclosure bed	
		<input type="checkbox"/> Bed Rails: <input type="checkbox"/> Half Rails <input type="checkbox"/> Full Rails <input type="checkbox"/> Bed Assist Rail	
Therapy Equipment		<input type="checkbox"/> Mattress:	<input type="checkbox"/> Foam Mattress:
<input type="checkbox"/> Ball Size: _____	<input type="checkbox"/> Peanut Ball Size: _____	<input type="checkbox"/> Low Air Loss Mattress:	
<input type="checkbox"/> Wedge Size: _____	<input type="checkbox"/> Rolls Size: _____	<input type="checkbox"/> Alternating Pressure:	
<input type="checkbox"/> Mat Length: _____ Width: _____ Thickness: _____		<input type="checkbox"/> ROHO Mattress Section (1) amount :	
Notes:		<input type="checkbox"/> Levelling Pad (1) amount:	
		Notes:	
Lift Systems		<input type="checkbox"/> Stroller	
<input type="checkbox"/> Floor To Ceiling Pole: <input type="checkbox"/> with superbar Ceiling Height: _____		Type: _____ Size: _____	
<input type="checkbox"/> Portable Lift System		Notes:	
<input type="checkbox"/> Sit To Stand Lift			
<input type="checkbox"/> Easy Track: <input type="checkbox"/> freestanding <input type="checkbox"/> tension mounted			
<input type="checkbox"/> Sling Type:		Standers	
Sling Size: <input type="checkbox"/> Child <input type="checkbox"/> Junior <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large		<input type="checkbox"/> Prone	<input type="checkbox"/> Supine
Notes:		<input type="checkbox"/> Sit-to-stand	
		Measurements:	
		Accessories/supports:	
Other Equipment (anything not listed):			
Comments or Special Instruction:			