HME HOME HEALTH

CMEDS EQUIPMENT LOAN REQUEST

(To be completed by the client's therapist)

*Mandatory Fields

Equipment Loan Request Form Submission Date: _____

CLIENT INFORMATION

*Name:		*DOB (**MM/DD/YYYY**):		☐ Palliative
*Height:	*Width:	*Depth:	*Leg Length:	*Weight:
*Address:		*City:	*Province:	*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):** _____ *City: _____

☐ **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
- ☐ Vernon Motion
- ☐ Kelowna Motion
- ☐ Penticton Motion
- ☐ Castlegar Kootenay Columbia Home Medical Equipment
- ☐ Kamloops National Seating & Mobility Canada
- ☐ Nanaimo National Seating & Mobility Canada (Advanced)
- ☐ Vernon National Seating & Mobility Canada
- ☐ Cranbrook Kootenay Columbia Home Medical Equipment
- ☐ Kelowna National Seating & Mobility Canada
- ☐ Prince George 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:
☐ Folding ☐ Rigid ☐ Tilt ☐ Hemi Height ☐ Transport

Seat to Floor (no cushion): Backrest Height:

Headrest: Footrests:

Seatbelt Type: ☐ Standard ☐ Other: _____

Transit Option: ☐ Yes ☐ No ☐ Stoller Handle

☐ Anti Tippers ☐ Laptray ☐ Calf Pad

Cushion Type:	Size:
Backrest Type:	Size:

Notes:

POWER WHEELCHAIR

Seat Width:	Seat Depth:

Tilt: ☐ With Tilt ☐ Without Tilt

Drive Type: ☐ Mid-Wheel ☐ Rear Wheel

Joystick: ☐ Left ☐ Right ☐ Attendant

Seat to Floor (no cushion): Backrest Height:

Headrest: Footrests:

Seatbelt Type: ☐ Standard ☐ Other: _____

Transit Option: ☐ Yes ☐ No

☐ Anti Tippers ☐ Laptray ☐ Calf Pad

Cushion Type:	Size:
Backrest Type:	Size:

Notes:

Ministry of Children and Family Development - All CMEDS Equipment Loan Requests must be submitted to MCF.

Email: MCF.MedicalBenefitsProgram@gov.bc.ca Toll-Free Phone: 1 (888) 613-3232 Fax: 1 (250) 356-2159

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LIFT SYSTEMS

☐ Floor to Ceiling Pole
Ceiling Height: _____ ☐ With Superbar

☐ Floor Lift | ☐ Free Standling Lift

☐ Sit to Stand Lift | ☐ Tension Mounted Lift

☐ Portable Motor only

☐ Sling
☐ Child ☐ Junior ☐ Small ☐ Medium ☐ Large
Sling Type: _____

**Note: CMEDS does not recycle or have access to fixed ceiling tracks or fixed motors*

Notes:

BATHROOM EQUIPMENT

☐ Raised Toilet Seat
☐ 2" ☐ 4" ☐ With Arms

☐ Commode STF: _____
☐ Wheeled ☐ Stationary ☐ Tilt ☐ Drop Arm

☐ Shower Commode
☐ With Tilt ☐ Without Tilt

☐ Pediatric Toilet Support
Type: _____ Size: _____

☐ Bathtub Transfer Bench
☐ Padded ☐ Unpadded ☐ Arm on Left ☐ Arm on Right

☐ Bathtub Chair
☐ With Back ☐ Without Back
☐ Small ☐ Medium ☐ Large

☐ Toilet Safety Frame ☐ Bath Board ☐ Bath Lift
☐ Tub Grip: _____

Notes:

THERAPY EQUIPMENT

☐ Ball Size: _____ | ☐ Peanut Ball Size: _____

☐ Wedge Size: _____ | ☐ Roll Size: _____

☐ Mat
Length: _____ Width: _____ Thickness: _____

Notes:

BEDS & MATTRESSES

☐ Hospital Bed
☐ Manual ☐ Electric ☐ Trendelendburg

☐ Bed Rails
☐ Half Rails ☐ Full Rails ☐ Bed Assist Rail

☐ Mattress
☐ Foam: _____
☐ Low Air Loss: _____
☐ Alternating Pressure: _____
☐ ROHO Mattress Section (1) amount: _____
☐ Leveling Pad (1) amount: _____

Notes:

WALKING AIDS

☐ Walker
☐ Stationary ☐ 2 Wheels ☐ 4 Wheels
☐ Anterior ☐ Posterior ☐ Other: _____
Handle Height: _____ Size: _____
Additional Supports Needed: _____

☐ Cane
Type: _____
Handle Height: _____ Size: _____

Notes:

ALTERNATIVE POSITIONING CHAIR

☐ Positioning Chair
Chair Width: _____ Chair Depth: _____
Chair Height: _____ ☐ Footrest needed

Notes:

STROLLERS, SCOOTERS, STANDERS

☐ Stroller
Type: _____ Size: _____

☐ Scooter
Make/Model: _____ Size: _____

☐ Stander
☐ Prone ☐ Supine ☐ Sit to Stand
Size: _____ Accessories/Supports: _____

Notes:

COMMENTS, SPECIAL INSTRUCTIONS, OR ANY EQUIPMENT NOT LISTED CAN BE ADDED ON THE NEXT PAGE

HME™
HOME HEALTH

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(To be completed by the client's therapist)

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: _____