

**CONVALESCENT EQUIPMENT
REQUISITION FORM
FAMILY & COMMUNITY SERVICES**

SECTION "A" CLIENT INFORMATION

NAME: _____ DATE OF BIRTH: ____ / ____ / ____
Day Month Year

ADDRESS: _____ TELEPHONE: _____

_____ FCS I.D. #: _____

PHYSICIAN: _____ MEDICARE #: _____

Is there other insurance coverage available? Yes No If yes, company and policy # _____

SECTION "B" EQUIPMENT INFORMATION

Current Equipment _____

Date obtained _____ Paid by? _____ Why is it no longer appropriate?

_____ Can it be recycled? Y N

Equipment Requested _____

SECTION "C" MEDICAL INFORMATION

Diagnosis/ medical condition _____

SECTION "D" CLIENT ASSESSMENT

Physical assessment: Weight _____

	Within Normal Limitations	Some Limitations*	Non-Functional*	Comments * if this space is insufficient, please use additional space on page 4
Upper Extremities				
Lower Extremities				

Functional assessment:

How does the client currently mobilize inside their home? _____

Is the client able to transfer independently? Bath Y N. Bed Y N. If no, please explain what assistance is required. _____

Equipment Trial: Assessment equipment was provided by: _____

The prescribed equipment assisted the client with:

- | | | |
|--|--|---|
| <input type="checkbox"/> Safety | <input type="checkbox"/> Mobility | <input type="checkbox"/> Maintenance of range of motion |
| <input type="checkbox"/> Preventions of contractures | <input type="checkbox"/> Pain control | <input type="checkbox"/> Skin integrity |
| <input type="checkbox"/> Comfort | <input type="checkbox"/> Safety of caregivers | <input type="checkbox"/> Participation in functional activities |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Independence with ADL's | <input type="checkbox"/> Bathing |
- Other (please explain) _____

Why was the prescribed make and model chosen? Which features are essential and why? _____

Was the client assessed with the recommended equipment in their home environment? Y N If no, please describe what measures have been taken to ensure that the client will be able to use it in his/her home? _____

Environmental factors:

Does the client live alone? Y N If no, is he/ she ever left alone? Y N If so, for what periods of time daily? _____ Does the client have attendants/ caregivers/ homemakers? Y N. If so, how many hours per day? ____ hrs. To assist with what tasks? _____

Projected Usage:

How long do you anticipate that the client will need this (these) item(s) _____

This equipment will be used: ____ times/day ____ times/week **OR** ____ hours/day ____ hours/week

- Please check all that apply: in their home in school for medical appointments
 for social activities outside the home for work/ vocation
 other (specify) _____

**** Seniors only**** Is this equipment available from the Red Cross Seniors Rehabilitation Program? Y N
Date checked _____

SECTION "E" ATTACHMENTS

- Quotation (s) Other _____
 Installation diagram (permanently installed equipment only)

**NOTES: 1) TO AVOID DELAYS, PLEASE ENSURE THAT THIS FORM IS COMPLETED IN FULL
2) ADDITIONAL INFORMATION MAY BE NECESSARY IN SOME SITUATIONS**

SECTION "G" CONSENT (HEALTH SERVICES COPY)

RE: _____ **EQUIPMENT:** _____
(Client name)

I _____ agree with the recommendations of the undersigned medical professional and I give consent to him/ her to release the enclosed information on my behalf to the Department of Family and Community Services, Easter Seals New Brunswick and any other agency who may be able to assist in the provision of the prescribed equipment.

I understand and accept the following terms of this loan:

- 1) The equipment provided may be new or recycled
- 2) I agree to care for it as I have been instructed and to have all repairs and maintenance carried out by a certified technician or qualified medical professional *
- 3) I agree to operate this equipment safely and not to abuse or misuse it in any way.
- 4) Once the equipment is no longer required, I will return it to Easter Seals NB for recycling.*

* Repairs, maintenance and shipping for this item are provided at no cost to you, if you have a valid Health Card with Family and Community Services and the terms of this loan agreement are upheld.

I have been provided with a copy of this agreement for my future reference.

Signature of Client/ / _____ Date _____
Designate/ Legal Guardian/ Sponsor
or Director of Nursing

Witness: _____ Date _____

Please forward entire package to: Health Services Claims
PO Box 5500, Fredericton, NB E3B 5G4
Fax: (506) 453-3960

REFERRING MEDICAL PROFESSIONAL:

Name: _____ Title: _____
(please print)

Telephone: _____ Facsimile: _____

Mail: _____ E-mail: _____

Signature: _____

Date submitted: to Health Services _____ to Easter Seals NB _____

SECTION "H" CONSENT (TO BE GIVEN TO THE CLIENT)

RE: _____
(Client name)

EQUIPMENT: _____

I _____ agree with the recommendations of the undersigned therapist and I give consent to him/ her to release the enclosed information on my behalf to the Department of Family and Community Services, Easter Seals New Brunswick and any other agency who may be able to assist in the provision of the prescribed equipment.

I understand and accept the following terms of this loan:

- 1) The equipment provided may be new or recycled
- 2) I agree to care for it as I have been instructed and to have all repairs and maintenance carried out by a certified technician or occupational therapist *
- 3) I agree to operate this equipment safely and not to abuse or misuse it in any way.
- 4) Once the equipment is no longer required, I will return it to Easter Seals NB for recycling.* (for more information, please contact them at 1-888-280-8155)

* Repairs, maintenance and shipping for this item are provided at no cost to you, if you have a valid Health Card with Family and Community Services and the terms of this loan agreement are upheld.

I have been provided with a copy of this agreement for my future reference.

Signature of Client/ _____ Date _____
Designate/ Legal Guardian/ Sponsor
or Director of Nursing

Witness: _____ Date _____

