CMEDS PROGRAM

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:

☐ ***By ticking the following box, the therapist confirms that consent has been obtained from the client's legal guardian to allow communication with HME regarding this request.**

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

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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.

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the Supply Act. The collected information may be subject to disclosure as per the Supply Act and/or the Freedom of Information and Protection of Privacy Act (FOIPP Act). If you have any questions about the collection, use, or disclosure of this information, please call HME at 1 844-821-0075.

*Therapist Signature: _____