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| **TO:** | | |
|  | **SUPPLIER** | **FAX NUMBER** |
|  | Embracor Medical | 506-854-2548 |
|  | Harding Medical, Moncton | 506 855-5113 |
|  | Lawtons Home Health Care, Moncton | 506-855-1838 |
|  | Lawtons Home Health Care, Saint John | 506 657-9742 |
|  | Ortho M L | 506-759-1094 |
|  | Restair Ltd | 506 684-5345 |
|  | Tango Medical, Fredericton | 506 452-7449 |
|  | Tango Medical, Moncton | 506 855-8843 |
|  | Tango Medical, Saint John | 506 634-7404 |

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| **CLIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Name | | | |  | | | | | | | | | | | | | Phone Number: | | | | | | |  | | | | | | | |
| Complete Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Health Card ID# | | | |  | | | | | | | | | | | | | Expiry Date: | | | | | | |  | | | | |  | |  |
|  | | | |  | | | | | | | | | | | | |  | | | | | | | DD | | | | | MM | | YYYY |
| **REQUEST DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date:** | DD | | MM | | | YYYY |  |  | | **URGENT** | | | | | | | | | | |  | | | | **NON URGENT** | | | | | | |
|  | |  | | |  |
|  | Assessment equipment | | | | | |  | | | Quote | | | | | |  | | Amended Request  Date: | | | | | | | | | | | | | |
| Substitutions acceptable for items requested below? | | | | | | | | | | | | | | | | Request for Cost sharing? | | | | | | | | | | | | | | | |
|  | Yes  (*Call to discuss with therapist)* | | | | | |  | | No | | | | | | |  | | | Yes | | | | | | |  | No | | | | |
| **Wheelchair Specifications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Manual Chair | |  | | | Folding | | | | | | |  | | Rigid | | | | | | | | |  | | | Tilt | | | | | |
| Model Name: | | | | | | | | | | | | | | | | | |  | | Standard | | | | | |  | | Hemi | |
| Power Chair | |  | | | FWD | | | | | | |  | | MWD | | | | | | | | |  | | | RWD | | | | | |
| Model Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Power Positioning: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Power Assist: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Alternative Drive Controls: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chair Size | | Seat Width: | | | |  | | | | | | | | | Seat depth: | | | | | | | | | | | | | | | | |
| Seat to floor height: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | With cushion | | | | | |  | | Without cushion | | | | | | | | | | | | | | | | | | |
| Front rigging: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leg Length: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Client Name |  | | | | | | | Health Card ID | |  |
| Cushion | Size: | | | | | | | | | |
| Type of Cushion: | |  | | | | | | | |
| 2nd cover required? | |  | Yes |  | No | | | | |
| Back | Width: | | | | | | Height: | |  | |
| Model: | | | | | | | | | |
| Arms | Style: | | | | | | | | | |
| Height: | | | | | | | | | |
| Wheels | Casters: | | | | | | | | | |
| Rear: | | | | | | | | | |
| Type of tires: |  | | | | | | | | |
| Hand Rims: |  | | | | | | | | |
| Wheel Locks |  | | | | | | | | | |
| Positioning  Accessories |  | | | | | | | | | |
| Other / Setup  and delivery  information |  | | | | | | | | | |

|  |  |
| --- | --- |
| **Convalescent Equipment** | |
| Type of Equipment | Specifications: (Brand/Size/Feature) |
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| **THERAPIST INFORMATION** | | | | | | | | |
| Name: |  | | | Location: | |  | | |
| Telephone |  | | | Fax: | |  | | |
| E-Mail |  | | | | | | | |
| Preferred method of Communication: | |  | E-mail |  | Phone | |  | Either |