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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 RequestDate:       |
| 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 |       |
| PositioningAccessories |       |
| Other / Setupand delivery information |       |

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| **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 |