



AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF BRITISH COLUMBIA

ALS Society of BC—Assistive Equipment Prescription Form

To assist in minimizing delays as well as costs incurred to the Society, **all requests** must include **this page** and any subsequent pages you have selected items on.

Once completed, please fax your request to 604-685-0725 You will receive an emailed confirmation indicating that your request has been received.

Date: _____ Pages Faxing: (*circle*) Page 1(mandatory), 2, 3, 4

Client's Surname: _____ First Name: _____

Street Address: _____ City: _____

Postal Code: _____ Phone Number: (____) _____

Requisitioned by: _____ Professional Designation: _____

Agency: _____ Telephone: (____) _____

Fax: (____) _____ Email: _____

Delivery information is MANDATORY.

Deliver to Home/Facility

Address same as above

Facility: (*Room #, Facility Name, Address*) _____

Deliver to Healthcare Professional or Local Medical Supplier (*write address*) :

Client family to Pick-up, (*please consider if Client is local to Lower Mainland & no installation is required*)

Contact Name: _____ Phone #: _____

Healthcare Professional would like to be present at delivery

This equipment request is: (*Circle one*) Urgent Necessary Optional

Is the equipment available through other agencies in your community such as home care? Please specify:

Have other funding sources been approached for this equipment (e.g. MSS, Extended Medical Plans, VAC or other)? Please specify:

208 – 1600 WEST 6th AVENUE, VANCOUVER, BC V6J 1R3 PH 604-685-0737 OR 1-800-708-3228 FAX 604-685-0725

Email: equipmentloan@alsbc.ca Website: www.alsbc.ca

CHARITABLE REGISTRATION # 10670 8985 RR0001

Mobility Aids

- Cane _____ handle height (select one) Quad Cane Regular Cane
- Folding Stationary Walker _____ Handle height
- 2 Wheeled Walker _____ Handle height
- 4 Wheeled Walker _____ Handle height _____ Seat height

Manual Wheelchairs & Scooters

- Transport Wheelchair (select one) 17 inches 19 inches
- Scooter (select one) 3 wheeled portable 3 wheeled non-portable 4 wheeled
- Manual Wheelchair - _____ (width) x _____ (depth) _____ Seat to floor without cushion
- Manual Tilt Wheelchair - _____ (width) x _____ (depth)
Back Height: _____ inches Seat to Floor Measurement (without cushion): _____ inches

Power Wheelchairs

**please note the below information assists the Society in providing the closest available match to your request. Exact brands may not be available.*

- Power wheelchair
- With Tilt Without Tilt
- Seat Width: _____ inches Seat Depth: _____ inches
- Back Height: _____ inches Seat to Floor Measurement (without cushion): _____ inches
- Drive Preference: Mid-Wheel Drive Rear-Wheel Drive
- Control: (select all that apply) Right Side Left Side Attendant Control
- Control Type: Joystick Goalpost

Wheelchair Options

- Seatbelt Anti-Tippers
- Full Lap tray 1/2 Lap Tray (circle one) Left/Right
- Headrest Specifications: _____
- Footrests: (select one) Platform Elevating Swing-away
- Backrest contour: (select one) Mild Moderate Aggressive

Cushions

_____ (width) x _____ (depth)

Gel ROHO High Profile

Foam basic ROHO Low- Profile

_____ Preferred Brand

Bathroom Aids

- Bath Seat** (*select one*) With Back Without Back
- Raised toilet seat** (*select one*) With Arms Without Arms
- _____ inches (height) **please note: we do not carry elongated Raised Toilet Seats*
- Toilet Safety Frame**
- Commode** (*select one*) Stationary Wheeled
- Drop arm needed? Yes No
- Wheeled Shower Commode**
- Tilt needed? Yes No
- Tub Transfer Bench** (*select one*) Arm on Right Arm on Left
- Tub Grip**
- Electric Bath Lift**

Lifts

- Portable patient lift** (*select one*) Regular Compact
- 2 post lift system**
- Sit to Stand Lift** (*limited number available*)
- Sling** (1 sling per patient member)
- Hammock Sling (*select size*) SMALL MEDIUM LARGE
- Universal/Quick fit Sling (*select size*) SMALL MEDIUM LARGE

Beds & Accessories

- Hospital Bed** (*select one*) Full Rails 1/2 Rails
- Nyaac portable bed rail
- Regular LTC 3000/4000 mattress** with sensus
- Specific Mattress** type required
- *OT will be contacted for specific mattress information*
- Roho mattress section** _____ quantity (*max. 3*)
- Leveling pads** _____ quantity
- Overbed Table**

