Ministry of Social Development and Social Innovation

BRITISH COLUMBIA

MEDICAL EQUIPMENT REQUEST AND JUSTIFICATION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance for Persons With Disabilities Act.* The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* If you have any questions about the collection, use or disclosure of this information, please contact your local Employment and Assistance Office.

PROGRAM OBJECTIVE: To provide the most basic, least costly medical equipment and devices to meet a medically essential need. Full details on eligibility criteria can be found on the ministry's Online Resource Policy Manual at: https://gww.hsd.gov.bc.ca/intranet/meia/online_resource

SECTION 1 - CLIENT INFORMATION (to be completed by worker)

CLIENT SURNAME	CLIENT GIVEN NAME	TELEPHONE OR MESSAGE	BIRTHDATE (YYYY MMM DD)	PERSONAL HEALTH NUMBER (PID) [care card #]
CLIENT STREET ADDRESS (IF RESIDENTIAL CARE FACILITY, NAME OF FACILITY)			CITY/TOWN	POSTAL CODE

1. IS CLIENT ELIGIBLE TO ACCESS MEDICAL EQUIPMENT UNDER THE EMPLOYMENT AND ASSISTANCE OR EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES REGULATIONS? Yes ☐ No ☐
2. ARE THERE OTHER RESOURCES AVAILABLE TO PROVIDE THE REQUESTED MEDICAL EQUIPMENT? (for example, ICBC, WorkSafeBC, Department of Veteran Affairs, private insurance) Yes ☐ No ☐

PLEASE EXPLAIN

SIGNATURE OF WORKER	OFFICE CODE	WORKER NUMBER	DATE SIGNED (YYYY MMM DD)

I HEREBY GIVE MY PERMISSION FOR ANY MEDICAL PRACTITIONER OR NURSE PRACTITIONER, HOSPITAL OR AGENCY TO GIVE ANY MEDICAL INFORMATION RELEVANT TO THIS APPLICATION TO THE MINISTRY OF SOCIAL DEVELOPMENT AND SOCIAL INNOVATION AND MY PERMISSION FOR THE MINISTRY OF HOUSING AND SOCIAL DEVELLOPMENT TO DISCUSS THIS REQUEST WITH THE EVALUATING PROFESSIONALS. THE MEDICAL EQUIPMENT RECOMMENDED HAS BEEN DESCRIBED TO ME AND I AGREE WITH THE RECOMMENDATIONS.

SIGNATURE OF CLIENT	DATE SIGNED (YYYY MMM DD)

SECTION 2 - MEDICAL OR NURSE PRACTITIONER RECOMMENDATION

NOTE: AN OCCUPATIONAL, PHYSICAL OR RESPIRATORY THERAPIST WILL PROVIDE THE DETAILED SPECIFICATIONS AND FUNCTIONAL ASSESSMENT CONCERNING THE MEDICAL EQUIPMENT REQUESTED.

DESCRIBE THE MEDICAL CONDITION OF YOUR PATIENT

WHAT TYPE OF MEDICAL EQUIPMENT IS RECOMMENDED?

SIGNATURE OF MEDICAL PRACTITIONER/NURSE PRACTITIONER	TELEPHONE	DATE SIGNED (YYYY MMM DD)

SECTION 3 - ASSESSMENT (TO BE COMPLETED BY OCCUPATIONAL, PHYSICAL OR RESPIRITORY THERAPIST)

AN ASSESSMENT SHOULD CONTAIN THE FOLLOWING INFORMATION:

OCCUPATIONAL OR PHYSICAL THERAPIST ASSESSMENT

- WHAT HAS PRECIPITATED THE REQUEST?
- WHAT ARE THE OUTCOMES/GOALS FOR USE OF REQUESTED EQUIPMENT/DEVICE?
- HEALTH INFORMATION
  - RELEVENT MEDICAL INTERVENTIONS (INCLUDE MEDICAL REPORTS IF APPLICABLE)
  - DIAGNOSIS/PROGNOSIS
  - HEIGHT AND WEIGHT

- FUNCTIONAL/ENVIRONMENTAL SUMMARY
  - FUNCTIONAL STATUS (I.E. MOBILITY, TRANSFERS, ADL SKILLS)
  - PHYSICAL SKILLS OR LIMITATIONS AS IT RELATES TO THE EQUIPMENT REQUESTED (I.E. HEAD CONTROL, ROM, VISION, BALANCE, ETC.
  - COGNITIVE SKILLS AS IT RELATES TO EQUIPMENT REQUEST (I.E. VISUAL SPATIAL SKILLS, JUDGMENT, ETC.

SAMPLE

Ministry of Social Development and Social Innovation

MEDICAL EQUIPMENT REQUEST AND JUSTIFICATION

- ENVIRONMENT AND OTHER SUPPORTS
  - CURRENT EQUIPMENT (RELATED TO REQUESTED EQUIPMENT)
  - INDICATE THE TYPE AND STATUS OF PRESENT EQUIPMENT AND WHY IT IS NO LONGER MEETING THE NEEDS OF THE CLIENT
  - WHAT REPAIRS OR MODIFICATIONS HAVE BEEN DONE TO CURRENT EQUIPMENT?
  - WHAT IS THE COST OF REPAIRING PRESENT EQUIPMENT
  - WHAT WAS THE FUNDING SOURCE OF THE CURRENT EQUIPMENT
- PRODUCT PARAMETERS
  - IDENTIFY POSSIBLE EQUIPMENT SOLUTIONS (IS THERE MORE THAN ONE POSSIBLE SOLUTION?)
  - SPECIFY PRODUCT PARAMETERS, AND PROVIDE MEDICAL JUSTIFICATION FOR EACH
- EQUIPMENT TRIALED
  - INDICATE EACH PIECE OF EQUIPMENT/DEVICE TRIALED AND OUTCOME OF TRIAL
  - DOCUMENT REASON FOR ELIMINATION OF SOME OPTIONS
- JUSTIFICATION
  - IDENTIFY THE RELATIONSHIP BETWEEN THE CLIENT'S MEDICAL NEEDS AND THE EQUIPMENT REQUESTED
  - PROVIDE JUSTIFICATION FOR COMPONENTS OF EQUIPMENT ESPECIALLY IF THEY ARE CONSIDERED TO BE “UP CHARGES”
  - INDICATE THE EXPECTED TARGETED OUTCOMES FOR THE EQUIPMENT REQUESTED

RESPIRATORY THERAPIST ASSESSMENT

- TRIAL
  - DIAGNOSTIC SLEEP TESTS (E.G. OVERNIGHT OXIMETRY ON ROOM AIR, DIAGNOSTIC POLYSOMNOGRAM)
  - QUOTE FROM SUPPLIER FOR TRIAL/RENTAL OF CPAP/BIPAP
- BUYOUT
  - THERAPEUTIC SLEEP TEST (E.G. OVERNIGHT OXIMETRY ON CPAP OR THERAPEUTIC POLYSOMNOGRAM)
  - COMPLIANCE REPORT
  - QUOTE FOR BUYOUT OF CPAP/BIPAP

SPECIFICATIONS OF MEDICAL EQUIPMENT REQUIRED TO MEET THE APPLICANT'S NEED		
THERAPIST NAME	ADDRESS	TELEPHONE
I CERTIFY I HAVE ASSESSED THE MEDICAL NEEDS OF THE APPLICANT IN SECTION 1 AND THE RECOMMENDED MEDICAL EQUIPMENT WILL SATISFY HIS/HER MEDICAL NEEDS.	SIGNATURE OF THERAPIST	DATE SIGNED (YYYY MMM DD)

NOTE: Forward completed form to:
Ministry of Social Development and Social Innovation, Health Assistance Branch,
P.O. Box 9971 STN PROV GOVT
Victoria, BC V8W 9R5

SAMPLE