BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

# ORTHOSES
# REQUEST AND JUSTIFICATION

SR#:

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 Act* and 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.* Any questions about this information should be directed to your local Employment and Assistance Office.

PROGRAM OBJECTIVE: To provide the most basic, least costly orthoses to meet a medically essential need. Full details on eligibility criteria can be found on the ministry's BC Employment & Assistance Policy & Procedure Manual at:
https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual

## SECTION 1 – CLIENT INFORMATION

| CLIENT SURNAME | CLIENT GIVEN NAME | PHONE NUMBER | BIRTH DATE | PERSONAL HEALTH NUMBER [CARE CARD] |
|---|---|---|---|---|
| | | | | |

| CLIENT STREET ADDRESS (IF RESIDENTIAL CARE FACILITY, NAME OF FACILITY) | CITY / TOWN | POSTAL CODE |
|---|---|---|
| | | |

PLEASE LIST AND DESCRIBE ANY ADDITIONAL RESOURCES THAT COULD ASSIST IN MEETING YOUR MEDICAL NEEDS (for example: ICBC, WorkSafeBC, Veterans Affairs, private insurance).

I HEREBY GIVE MY PERMISSION FOR ANY MEDICAL PRACTITIONER OR NURSE PRACTITIONER, EVALUATING HEALTH PROFESSIONAL, HOSPITAL OR AGENCY TO GIVE ANY MEDICAL INFORMATION RELEVANT TO THIS APPLICATION TO THE MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION AND SERVICE PROVIDER. I GIVE MY PERMISSION FOR THE MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION TO DISCUSS THIS REQUEST WITH THE EVALUATING PROFESSIONALS AND SERVICE PROVIDER. THE ORTHOSIS RECOMMENDED HAS BEEN DESCRIBED TO ME AND I AGREE WITH THE RECOMMENDATIONS.

| CLIENT SIGNATURE | DATE SIGNED (YYYY-MMM-DD) |
|---|---|
| | |

## SECTION 2 – MEDICAL OR NURSE PRACTITIONER RECOMMENDATION

DESCRIBE THE MEDICAL CONDITION OF YOUR PATIENT (PLEASE PRINT)

WHAT TYPE OF ORTHOSIS IS RECOMMENDED? (PLEASE PRINT)

IS A CUSTOM-MADE ORTHOSIS REQUIRED? ☐ YES ☐ NO

IF THE ORTHOSIS IS A **KNEE BRACE**, WILL IT BE REQUIRED AT LEAST **6 HOURS** PER DAY? ☐ YES ☐ NO

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

| PRINT NAME | PHONE NUMBER | FAX NUMBER |
|---|---|---|
| | | |

| POSITION/TITLE | PROFESSIONAL REGISTRATION NUMBER |
|---|---|
| | |

**NOTE: IF CUSTOM ORTHOSIS REQUIRED, PLEASE REFER PATIENT TO AN ORTHOTIST, PEDORTHIST, PODIATRIST, OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST**

## SECTION 3 – ASSESSMENT (TO BE COMPLETED BY ORTHOTIST, PEDORTHIST, PODIATRIST, OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST)

**IMPORTANT:** PLEASE ATTACH A DETAILED QUOTE.

1. SPECIFICATIONS OF THE ORTHOSES REQUIRED TO MEET THE APPLICANT'S NEEDS.

2. PLEASE EXPLAIN HOW THE PRESCRIBED ITEM WILL ASSIST WITH JOINT MOTION AND/OR SUPPORT.

3. IS THE ITEM REQUIRED FOR ONE OR MORE OF THE FOLLOWING PURPOSES?

| | | |
|---|---|---|
| A. PREVENTION OF SURGERY | ☐ YES | ☐ NO |
| B. FOR POST SURGICAL TREATMENT | ☐ YES | ☐ NO |
| C. TO ASSIST IN PHYSICAL HEALING FROM SURGERY, INJURY OR DISEASE | ☐ YES | ☐ NO |
| D. TO IMPROVE PHYSICAL FUNCTIONING THAT HAS BEEN IMPAIRED BY A NEURO-MUSCULO-SKELETAL CONDITION | ☐ YES | ☐ NO |

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN

4. IF THE ORTHOSIS IS A CUSTOM-MADE FOOT ORTHOTIC, WILL IT BE MADE FROM A HAND CAST MOLD?

☐ NO ☐ YES

PLEASE EXPLAIN

5. IF THE ORTHOSIS IS A KNEE BRACE, PLEASE INDICATE THE MAKE AND MODEL.

6. IF THERE IS ANY OTHER INFORMATION THAT MAY BE RELEVANT TO THIS APPLICATION, PLEASE EXPLAIN. (FOR EXAMPLE, WHAT IS THE CONDITION OF THE CURRENT DEVICE?)

| SIGNATURE OF PERSON PROVIDING CLINICAL TREATMENT | DATE SIGNED (YYYY-MMM-DD) |
|---|---|
| PRINT NAME | PHONE NUMBER |
| POSITION/TITLE | CANADIAN PROFESSIONAL REGISTRATION NUMBER |

## FAX COMPLETED FORM TO: 1-855-771-8785

OR

**MAIL:** Ministry of Social Development and Poverty Reduction,
Health Assistance, P.O. Box 9971 STN PROV GOVT Victoria, BC V8W 9R5