

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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Section 2 – Devices and Eligibility

Diagnosis: (to be completed by Physician/Nurse Practitioner where applicable)

☒ Hypertrophic Scarring

Chronic Lymphedema

☐ Primary ☐ Secondary

Surgical Procedure (if applicable)

Kidney transplant

Date of Surgery (yyyy/mm/dd)

2017-05-06

Section 2a - Hypertrophic Scar Management Devices (to be completed by Authorizer)

Device(s) Required:

Mask

☒ Face Mask

☒ Chin Strap / Neck Support

☐ Accessories

Trunk

☒ Vest - sleeveless

☒ Vest - short sleeves

☐ Vest - two sleeves

☐ Chest Brace / Bolero

☒ Body Brief - sleeves

☐ Body Brief - sleeveless

☒ Body Brief - legs

☐ Body Brief - legs & sleeves

☒ **Options - Garments**

☐ **Interim Care Garments**

Lower Extremity

Foot Gloves

☒ Left ☐ Right

Anklet / Sock

☐ Left ☒ Right

Leg Tube

☐ Left ☒ Right

Stockings - knee length

☒ Left ☐ Right

Stockings - thigh length

☒ Left ☐ Right

Stockings - waist high (one leg)

☒ Left ☐ Right

Stockings – chaps style (one leg)

☒ Left ☐ Right

☒ Stockings - waist high (two legs)

☒ Stockings - chest high

☒ Panty Girdle

☒ Penile Support

☒ Stockings - chaps style (two legs)

Upper Extremity

Mittens

☐ Left ☒ Right

Gauntlet

☐ Left ☒ Right

Glove

☐ Left ☒ Right

Finger Supports

☐ Left ☒ Right

Half Sleeve

☒ Left ☐ Right

Sleeve

☐ Left ☒ Right

Sleeve with shoulder flap

☐ Left ☒ Right