Applicant's Last Name	First Name	Health Number (10 digits)	Version

Orthotics

Wrist-hand-finger	☐ Left	☑ Right
Elbow-wrist-hand-finger	☐ Left	☑ Right
Elbow-wrist-hand-finger (bi-valved)	☐ Left	☑ Right
Axilla Splint	☑ Left	☐ Right
Ankle-foot	☐ Left	☑ Right
Ankle-foot (bi-valved)	☐ Left	☑ Right

☐ Face Mask

☐ Neck Brace

Reason for Application (check one) (to be completed by Authorizer)

☑ First access to ADP for Hypertrophic Scar Management Devices

☐ Additional Devices/Options to other ADP Funded Hypertrophic Scar Management Devices

☐ Replacement of Previously ADP Funded Hypertrophic Scar Management Devices

Replacement Required Due To: (check as applicable) (to be completed by Authorizer)

☐ Change in medical condition

☑ Physical Growth/Atrophy or tissue healing

☑ Normal wear and applicant confirms that it is no longer under warranty

Confirmation of Applicant's Eligibility for Hypertrophic Scar Management Devices (to be completed by Authorizer)

Applicant requires a compression garment and/or a compression orthosis for hypertrophic scar management for a minimum of six (6) months of regular daily use. ☐ Yes ☑ No ☐ N/A

Section 2b – Lymphedema Management Devices (to be completed by Authorizer)

Device(s) Required:

Mask

☐ Face Mask ☐ Chin Strap / Neck Support ☑ Accessories

Trunk

☑ Vest - sleeveless ☑ Vest - short sleeves ☐ Body Brief - sleeveless ☑ Body Brief - sleeves

☑ **Options - Garments**

Lower Extremity

Foot Gloves	☐ Left	☑ Right
Foot Cap	☑ Left	☐ Right
Stockings – foot to knee	☑ Left	☐ Right
Stockings – foot to thigh	☐ Left	☑ Right
Stockings – foot to thigh with waist attachment	☐ Left	☑ Right
Stockings - waist high (one leg)	☐ Left	☑ Right
Stockings – chaps style (one leg)	☐ Left	☑ Right

☐ Stockings - waist high (two legs)

☑ Stockings - chest high

☑ Stockings - chaps style (two legs)