# Medical Equipment Provisioning Program (MEPP) PROCEDURE

## Summary of Changes

| | NEW | Previous |
|---|---|---|
| **BC Cancer** | December 6, 2019 | June 17, 2019 |

# 1. Introduction

## 1.1. Focus

The Medical Equipment Provision Program (MEPP) is a provincial program that provides a clear, consistent and equitable process for providing home use medical equipment to patients across all of BC's Health Authorities. MEPP supports patients that do not have alternative funding sources. In these cases, the applicable Regional Health Authority will pay for equipment rental. Clinicians are not involved in the payment process.

The MEPP program provides equipment **loans** to patients leaving hospital or receiving health care services at home. Patients must have an immediate short term equipment need for recovery, safety or to reduce caregiver injury.

Where patients **do** have access to alternative funding sources, such as insurance or self-pay, the clinician may still help facilitate equipment rental or purchases, but this process does not apply.

## 1.2. Site Applicability

This practice applies primarily to the BC Cancer dietetic and physiotherapy services, but may apply to other areas if a referral to community home care for equipment is not possible or if there are anticipated lengthy delays.

## 1.3. Practice Level

This practice applies to BC Cancer dietitians and physiotherapist.

## 1.4. Definitions

**Advanced equipment:** requires professional installation to ensure safe use of the device or specific clinical skills to prescribe (e.g. lifting device, medical bed, floor-to-ceiling pole).

**Basic equipment**: supports ADL and mobility (e.g. IV pole, or standard wheelchair). This equipment is picked up and returned by the client.

**CRC:** The Canadian Red Cross, who is the preferred provider.

**MEPP:** Medical Equipment Provision Program

**Patient:** the patient and their chosen care partners who are acting on the patient's behalf.

**Palliative equipment eligibility**: patients who are registered with the provincial Palliative Care Benefits Program and who are receiving services from and are registered with a Regional Health Authority Palliative Team.

**Private contracted vendor:** Contracted vendors other than CRC

**Short term:** equipment provided for 6 months or less

**Vendors:** CRC and private contracted vendors that supply equipment to patients

### 1.5. Equipment and Supplies

Applicable forms/documents:

1. MEPP Patient Brochure (Appendix A)
2. MEPP List of vendors (Appendix B)
3. MEPP Equipment List
4. Referral Form (Appendix C)
5. Equipment Specifications Form (Appendix D)
6. Extension form (Appendix E)

## 2. Procedure

### 2.1. Steps

2.1.1 Complete an equipment needs assessment:

- The clinician will complete an assessment to identify the patient's need for equipment.
- MEPP criteria:
  - The patient has an immediate short term equipment need for recovery, safety or to reduce caregiver injury; and,
  - The patient is leaving hospital or receiving health care services at home.

2.1.4 Confirm if the patient has alternative funding sources:

- Review the MEPP Patient Brochure (Appendix A) with the patient outlining possible funding sources, such as:
  1. Extended Medical Programs such as Pacific Blue Cross, Sun Life, and Manulife.
  2. Other sources:

- Ministry of Social Development and Social Innovation
- Veterans Affairs Canada
- First Nations Health Authority/Inter-Tribal Health Authority
- Service Clubs, for example, Kinsmen, Variety Club
- Societies, for example, Multiple Sclerosis Society of Canada

3. Patient Self Pay

- Where patients **do** have access to alternative funding sources, the clinician may still help facilitate equipment rental or purchases; however this process does not apply.
    - Support the patient in obtaining equipment as appropriate, for example completing supporting paperwork. Note each funding source (e.g. insurance company) will have specific requirements and forms for completion. Provide the Equipment Specification Form if needed, for example, the patient prefers to self-pay utilizing vendors under contract.
    - If alternative funding is delayed and poses an urgent safety requirement, follow the MEPP process for short-term until alternate funding is available.
- Where the patient has **no access** to alternate source funding, the MEPP process below.

2.1.2 Check the MEPP List of Vendors (Appendix B)

- The Canadian Red Cross (CRC) is the preferred provider.
- If CRC is not reasonably located near the patient's home then a private contracted vendor can be used.
- Detailed list of vendors also available or in MEPP Patient Brochure.

2.1.3 Check the MEPP Equipment List (see separate MEPP Equipment List document)

- Check the vendor equipment lists to confirm if equipment is available:
    - If the equipment is on the CRC list, proceed with referral to CRC.
    - If the equipment is not on the CRC list, or cannot be provided in the required time-frame, proceed with referral to a private contracted vendor.

2.1.6 Complete the required forms:

- MEPP Referral Form (Appendix C)
- MEPP Equipment Specifications Form (Appendix D)

- Provide patient with the MEPP Patient Brochure, completed Referral Form and Equipment Specification Form.
- Inform the patient they are responsible to pick up and return the equipment from the vendor.
- Provide the patient with the location for pick up and return of the equipment.
- Send copies of the completed forms to HIM for upload into the patient medical record.

2.1.7 Equipment Extension

- If patient communicates that the equipment is required beyond the anticipated length as specified on the original referral form, complete the Equipment extension form (Appendix F) and fax to the vendor.
- If the patient is no longer a patient of BC Cancer, refer the patient to the relevant community home care service to request the rental extension.

## 2.2. Site Specific Practices

None

## 2.3. Documentation

Document in the patient's medical record:

1. Confirmation that the MEPP Patient Brochure was reviewed with the patient;
2. Confirmation that the appropriate forms were completed, and provided to the patient or sent to the vendor. Send copies of the completed forms to HIM for upload into the patient medical record.

## 2.4. Patient Education

1. MEPP Brochure

## APPENDIX A: MEPP Patient Brochure

### VENDOR CONTACT INFORMATION

**FRASER HEALTH REGION**
CANADIAN RED CROSS
Basic equipment: 604-930-9049
Advanced equipment delivery, installation and return: 604-930-9073

OTHER VENDORS
**BC Medequip Home Health Care Ltd**
Burnaby 604-888-8811
**Selfcare Home Health Product**
Tricities (Port Coquitlam, Coquitlam, Port Moody, Maple Ridge, Mission, Pit Meadows) Communities
North of the Fraser River 604-944-9644
Abbotsford 604-574-5601
**HME Mobility & Accessibility**
South Surrey 604-535-5768

**VANCOUVER COASTAL HEALTH REGION**
CANADIAN RED CROSS
Basic equipment: 604-301-2566
Advanced equipment delivery, installation and return: 604-270-4224

OTHER VENDORS
**BC Medequip Home Health Care Ltd**
Burnaby 604-888-8811
**Selfcare Home Health Product**
Vancouver North Shore 604-990-9422
Vancouver 604-872-5800
**HME Mobility & Accessibility**
Richmond 604-821-0075
**Coast Ability**
Sechelt 604-747-4722 (select Option 1)
Powell River 604-489-4722

**VANCOUVER ISLAND HEALTH REGION**
CANADIAN RED CROSS
Basic equipment and Advanced equipment delivery, installation and return: 250-382-2043

OTHER VENDORS
**G.T. Medical Care Equipment (Life Support Assisted Living Systems)**
Parksville 250-954-0309 or 1-800-224-8662
**Island Mediquip Ltd.**
Victoria 250-391-0388 or 1-800-231-7188
Duncan 250-597-0151 or 1-800-231-7188
Nanaimo 250-824-0390 or 1-800-231-7188
Courtenay 250-871-0366 or 1-800-231-7188
Campbell River 778-346-1073 or 1-800-231-7188
**HME Mobility & Accessibility**
Victoria 250-386-0075

**INTERIOR HEALTH REGION**
CANADIAN RED CROSS
Basic equipment: 250-765-3465
Advanced equipment delivery, installation and return: 250-491-8443 ext. 220

OTHER VENDORS
**Kootenay Columbia Home Medical Equipment**
Cranbrook 250-426-6000 or 1-800-661-4022
Castlegar 250-365-7772 or 1-866-515-7772
Vernon 1-250-549-7288 or 1-866-942-7288
Kamloops 1-236-425-1235 or 1-844-259-8576
Kelowna 1-236-420-7288
**PG Surg Med**
Prince George 1-250-564-2240 or 1-800-663-2963
Vernon 1-250-549-7288 or 1-866-942-7288
Kamloops 1-236-425-1235 or 1-844-259-8576
Kelowna 1-236-420-7288

**NORTHERN HEALTH REGION**
CANADIAN RED CROSS
Basic equipment and Advanced equipment delivery, installation and return: 250-564-6666

OTHER VENDORS
**PG Surg Med**
Prince George 1-250-564-2240 or 1-800-663-2963
**North Coast Home Medical Equipment**
Terrace 250-638-1301

Visit www.redcross.ca/bc for contact details for your nearest location.

# MEDICAL **EQUIPMENT** PROVISION **PROGRAM**

The Medical Equipment Provision Program provides medical equipment for patients and clients in B.C. leaving the hospital or receiving health care services at home. To receive this equipment, you must be assessed by a health authority clinician to have an immediate short-term equipment need for your recovery or safety, or to reduce caregiver injury.

Your health authority clinician will assist you with the equipment rental from the Canadian Red Cross or other vendor if they determine you do not have another source of funding.

Your health authority clinician will determine how long the equipment will be rented for you.

### HOW DO I GET THE EQUIPMENT I NEED?

Your clinician (such as occupational therapist, physical therapist, or nurse) will assess your needs and prescribe the equipment.

You will receive two forms:

- a referral form that approves the rental through the equipment vendor. This form also includes the date the equipment must be returned and where to return the equipment.
- an equipment form that tells the equipment vendor what equipment you need.

Follow the instructions of your clinician:

_____

_____

_____

### HOW DO I RETURN THE MEDICAL EQUIPMENT?

It is your responsibility to return the equipment to the equipment vendor by the date on the referral form.

- You can return Canadian Red Cross equipment to any depot in B.C. See information on the following pages.
- Equipment from other vendors need to be returned to the same vendor.
- If the equipment was installed by the equipment vendor, they should contact you to arrange to have it removed from your home. If you do not receive a call, or want the equipment to be removed earlier, call one of the numbers on the following pages. It is your responsibility to have the equipment returned by the due date, or sooner, if you no longer need it.

### WHAT IF I HAVE QUESTIONS ABOUT THE RENTAL EQUIPMENT AND/OR NEED TO KEEP THE EQUIPMENT LONGER?

If you have questions about the equipment or will need to keep the equipment longer, call your health authority clinician prior to the return date.

Contact information to reach your health authority clinician:

_____

Additional instructions:

_____

_____

## APPENDIX B: MEPP List of Vendors

**Vancouver Area**

1. Canadian Red Cross:
    a. 600 W Queens Rd, North Vancouver
    b. 5000 Joyce Ave, Powell River
    c. 101-3850 Jacombs Rd, Richmond
    d. 38140 Behrner Dr, Squamish
    e. 209 6th Ave, Vancouver
2. BC Medequip: 2230 Springer Avenue, Burnaby
3. Selfcare: 1340 Pemberton Avenue, North Vancouver
4. Coast Ability 4 – 7030 Glacier Street, Powell River
5. HME Mobility Unit 130, 4011 Viking Way, Richmond

**Fraser Health Area**

1. Canadian Red Cross:
    a. 105 - 7355 Canada Way, Burnaby
    b. #5 - 11435 201A St, Maple RIdge
    c. 104 - 1776 Broadway St, Port Coquitlam
    d. 475 Guildford Way, Port Moody
    e. 106 - 20530 Langley Bypass, Langley
    f. 109-14727 108th Ave, Surrey
    g. 16- 1480 Foster St, White Rock
    h. 1-34220 South Fraser Way, Abbotsford
    i. 9290 Mary St, Chilliwack
2. BC Medequip: 2230 Springer Avenue, Burnaby
3. Selfcare: Unit 114, 1533 Broadway, Port Coquitlam
4. Selfcare: Unit 4, 17675 64 Avenue, Surrey
5. HME Mobility Unit 140,-19288 22Avenue,

**Vancouver Island**

1. Canadian Red Cross:
    a. 909 Fairfield Rd, Victoria
    b. 1952 Bay St, Victoria (satellite)
    c. 1 Hospital Way, Victoria (satellite)
    d. 135 Crofton Rd, Salt Spring Island
    e. #3-2525 McCullough Rd, Nanaimo
    f. 1665 Grant Ave, Nanaimo
    g. #2-5855 York Rd, Duncan

   h. 1111 Fourth Ave, Ladysmith
   i. 121 Point Ideal Rd, Lake Cowichan
   j. 5100C Tebo Ave, Port Alberni
   k. 949 Port Alberni Hwy, Port Alberni
   l. 464 Puntledge Rd, Courtenay
   m. 2137 Comox Ave, Comox (satellite)
   n. 140-520 Second Ave, Campbell River
   o. 1306 Sayward Rd, Sayward
   p. 9150 Granville St, Port Hardy
   q. 901 Marine Dr, Port Alice
2. HME Mobility: 2521 Government Street, Victoria
3. GT Medical: 1270 Alberni Hwy, Parksville
4. Island Mediquip:
   a. 101-750 Enterprise Crescent, Victoria
   b. 2258 Dorman Road, Nanaimo
   c. 1063 Canada Ave., Duncan
   d. #9-204 Old Island Highway, Courtenay
   e. 1454 Ironwood Street (Common Mall), Campbell River
   f. #9-204 Old Island Highway, Courtenay

**Interior Health:**

1. Canadian Red Cross:
   a. 124 Adams Rd, Kelowna V1X 7R2
   b. 2268 Pandosy St, Kelowna (satellite)
   c. 2466 Main St, West Kelowna V4T 1Z1
   d. 10130 Bottom Wood Lake Rd, Central Okanagan
   e. 2116 Main St, Cawston
   f. 104A - 575 Main St, Penticton
   g. 148 Old Hedley Rd, Princeton
   h. 146 Spruce Ave, Oliver
   i. 710 Granville Ave, Enerby
   j. 2809 44th Ave, Vernon
   k. 2101 32bd St, Vernon
   l. 1250A 26th St, Castlegar
   m. 7642 22nd St, Grand Forks
   n. 673 A Ave, Kaslo
   o. 614 Front St, Nelson
   p. 123 - 8100 Rock Island Hwy, Trail
   q. 340-1311 2nd St North, Cranbrook
   r. 312 15th Ave North, Creston
   s. 212 Alpine Ave, Elkford
   t. 1501 5th Ave. Fernie
   u. 1030 10th St, Invermere

v. 215 4th St, 100 Mile House
w. 700 Elm St, Ashcroft
x. 132 Clearwater Station Rd, Clearwater
y. 943 Victoria St, Kamloops
z. 951 Murray St, Lillooet
aa. 3451 Voght St, Merritt
bb. 1401 W 1st St, Revelstoke
cc. 150-2960 Old Okanagan Hwy SE, Salmon Arm
dd. 517 N 6th Ave, Williams Lake

2. Kootenay:
    a. 630 17th Street, Castlegar BC
    b. 250 Slater Road, Cranbrook BC
3. PG Surgmed:
    a. 200 – 1546 Harvey Ave, Kelowna
    b. 4026 25th Ave, Vernon
    c. 25A 1967 E. Trans Canada Highway, Kamloops

**Northern Health**

1. Canadian Red Cross:
    a. 5500 Hospital Rd, Chetwynd
    b. 11100 13th Ave, Dawson Creek
    c. 5315 Laird St, Fort Nelson
    d. 9620 Sikanni Road, Fort St. John
    e. 920 Lahakas Blvd N, Kitimat
    f. 60 Centennial Dr, MacKenzie
    g. 1399 6th Ave, Prince George
    h. 155 McDermid Dr, Prince George (satellite)
    i. 1475 Edmonton Ave, Prince George (satellite)
    j. 1305 A Floor Summit Ave, Prince Rupert
    k. 543 Front St, Quesnel
    l. 3950 8th Ave, Smithers
    m. 4720 Lazelle Ave., Terrace
2. NorthCoast:
    a. Wrinch Memorial Hospital 2510 Hwy 62 Hazelton
    b. 14th Street Houston
    c. Kitimat General Hospital & Health Center 920 Lahakas BLVD
    d. Northern Haida Gwaii Hospital 2520 Harrsion Ave
    e. Prince Rupert Regional Hospital 1305 Summit Ave
    f. Queen Charlotte Islands General Hospital 3209 Oceanview Drive
    g. Buckley valley District Hospital, 3950 8th Ave, Smithers
    h. Northcoast Home Medical 4443 Keith Ave Terrace
3. PG Surgmed: 1749 Lyon St, Prince George

## APPENDIX C: Referral Form

### MEDICAL EQUIPMENT PROVISION PROGRAM
### REFERRAL FORM

FAX FORM TO: _____

**Client Referring Health Authority:** ☐ FHA ☐ IHA ☐ NHA ☐ PHSA ☐ VCH ☐ PHC ☐ VIHA
**Client Home Health Authority:** ☐ FHA ☐ IHA ☐ NHA ☐ PHSA ☐ VCH ☐ PHC ☐ VIHA
☐ Acute Care ☐ Community Health Services ☐ Health Authority Clinic ☐ Other _____

**Client Information:**

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: (DD/MM/YY) _____ PHN: _____ Gender: ☐ Male ☐ Female ☐ Prefer not to disclose

Address: _____ City: _____ Postal Code: _____

Phone #1: _____ Phone #2: _____

Alternate/Caregiver Contact Name: _____ Phone: _____

Delivery Contact (if required): _____ Phone: _____

Communication Support Needs: ☐ No ☐ Yes (If yes, use alternate contact)

Anticipated length of rental: ☐1 ☐2 ☐3 week(s) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 mth(s) Due date: _____

☐ Eligible for Palliative Benefits ☐ Long Term Need (>6 mths) (FH and VCH/PHC only)

Requires equipment within: ☐ <24 Hours Urgent ☐ 1-3 Days Priority ☐ 4-5 Days Non-Priority

(**NOTE**: <24 Hours requires a phone call to the vendor to confirm availability)

Referral date: _____ Discharge Date (if known): _____

(For information on Health Care Professional authorized equipment, **See Equipment Specifications List** – attached)

**Advanced Equipment Installation Instructions:**

Installation required: ☐ Yes ☐No If equipment requires installation, complete the following information:

Clinician to be present during delivery: ☐Yes ☐No Clinician to be notified of installation: ☐ Yes ☐ No

Additional Information: _____

Clinician Name: _____ Professional Designation: ☐OT ☐PT ☐RN

Phone: _____ Fax: _____

**Referring Health Care Professional:**

Full Name: _____ Signature _____ Phone: _____

Professional Designation: ☐ RN ☐ OT ☐PT ☐Other _____

Site/Department: _____

Instructions for Pick-up: _____

**Additional Authorization for Health Authority Funded Equipment (if other than the Referring HCP, sign below ):**

Name: _____ Signature: _____ Position: _____

**Authorization to be signed by Client eligible for Health Authority funded equipment:**

☐ The Medical Equipment Provision Program has been reviewed with me and I acknowledge I meet the requirements of the program.

☐ I hereby authorize the BC Health Authority Staff and/or its representatives to release or to obtain from such agencies, individuals, medical centres or hospitals, any and all pertinent information which may be necessary to assist in providing or obtaining essential medical equipment on my behalf. I consent to the collection, use and disclosure of the personal information provided in accordance with the [insert HA] Privacy Policy, until I notify you otherwise. If you have any questions about the collection of information, speak to the Health Authority contacts above. I understand this equipment is prescribed for the period stated above and must be returned when required or instructed to do so.

Client/Representative Signature: _____

Client/Representative Printed Name: _____ Date: _____

**Instructions**: Health Care Professional to complete the Referral Form and Equipment Specifications Form.
Fax Referral Form and Equipment Specifications List to specified vendor. Original to be filed in client's Health Record.

fraserhealth northern health Vancouver Coastal Health Providence Health Care Provincial Health Services Authority island health

Final Mar 6 2019

## APPENDIX D: Equipment Specifications Form

MEDICAL EQUIPMENT PROVISION PROGRAM
EQUIPMENT SPECIFICATIONS LIST

Fax to _____

**Client Name:** **Weight kg/lb:** **Height cm/ft:**

**BATHROOM**
☐ Bath Chair ☐ Back ☐ No Back ☐ Bariatric
☐ Bath Board ☐ Flush ☐ Raised
☐ Bath Transfer Bench ☐ Arm on Lt ☐ Arm on Rt
☐ Padded ☐ Plastic ☐ Either ☐ Bariatric
Tub wall height (outside)____ in
☐ Bathtub safety rail - Clamp on
☐ Commode: Seat to floor height _____ in
☐ Stationary ☐ Stationary Bariatric ☐ Wheeled ☐ Shower
☐ *Tilt ☐ Pediatric ☐ Shower Chair self-propelling wheels
☐ Raised Toilet Seat, Round (Clamp on)
☐ 2 in ☐ 4 in ☐ 5 in ☐ 6 in ☐ w/arms ☐ w/o arms
☐ Raised Toilet Seat, Elongated (Bolted on) 3.5 in w/o arms
☐ Toilet Safety Frame (attachable)

**WHEELCHAIR**
☐ Manual ☐ Reclining (with headrest) ☐ Transport ☐ Bariatric
☐ Lightweight folding basic ☐ *Tilt ☐ *Headrest (tilt WC only)
☐ Pediatric (Circle: 12 x 12, 14 x 14, 16 x 16)
Seat width _____ in Seat depth_____ in
Finished seat to floor ht _____in (including cushion)
☐ Removable armrests ☐ Adjustable armrests ☐ Anti-tippers
☐ Elevating leg rests ☐ Lt ☐ Rt ☐ Both
☐ No Cushion ☐ Foam Cushion (Circle: 2 in, 3 in, 4 in)
**Items ONLY For Specialized Need:**
☐ ***Backrest:** ☐ *Personal Back ☐ *Other backrest (as available)
☐ ***Cushion:** Size: width _____ in X depth _____in
☐ *Air (e.g. ROHO) (Circle: Low profile, High profile)
☐ *Contoured Foam ☐ *Air/Foam ☐ *Gel ☐ *Foam/Fluid
☐ ***Amputee Board**
Comments:

**BEDS/MATTRESSES**
☐ *Electric Hospital Bed ☐ *Bariatric Bed
☐ *Bed rails ☐ Half ☐ Full (full rails not available in Bariatric)
**Overlay:** *Reactive, Non-powered:
☐ *Gel (e.g. Gel pad)
☐ *Air ROHO - number of: sections ___ levelling pads___
Indicate sections: Head ☐☐☐☐ Foot
**Mattress:**
*Reactive, Non-powered: ☐ Single Zone ☐ Multi zone
☐ Foam ☐ Gel ☐ Air
*Reactive, Powered: ☐ Low Air Loss ☐ Non Air Loss
*Active, Powered: ☐ Low Air Loss ☐ Non Air Loss
☐ Rotational Support ☐ Alternating Pressure

**WALKING AIDES**
**Walker handgrip to floor height: _____ in**
☐ Standard Walker
☐ No Wheels ☐ Two Wheels
☐ Adult ☐ Toddler ☐ Pediatric ☐ Tall ☐ Bariatric
☐ Skis (recommended for carpet)
☐ Gutter Attachment ☐ Lt ☐ Rt ☐ Both
Gutter to floor height _____ in
☐ Side Stepper/Hemi walker
☐ 4 Wheeled Walker ☐ Bariatric
Gutter attachment ☐ Lt ☐ Rt ☐ Both
Gutter to floor height _____ in
☐ Cane ☐ Single ☐ Pair Handgrip to floor height_____ in
☐ Contoured Grip handle (Lt or Rt) ☐ Bariatric
☐ Quad Cane ☐ Lt side ☐ Rt side Height_____ in
☐ Crutches ☐ Axilla ☐ Axilla Pediatric ☐ Axilla Bariatric
☐ Forearm ☐ Forearm cane (gutter crutch)
Crutch height _____ in
Handgrip to floor height _____ in
☐ Gutter attachment ☐ Lt ☐ Rt ☐ Both
Gutter to floor height ____ in

**PATIENT LIFTS/INSTALLED MOBILITY AIDES (Advanced Items)**
☐ *Threshold Ramp Location: _____
Width _____X Length _____ X Height (Max 3 in)_____
☐ *Floor to Ceiling Poles
Height: _____ Location: _____
Horizontal Bar ☐ Yes ☐ No (Bar ht fixed at 32.5 in from floor)
Install information: _____
☐ *Non-mechanical Sit to Stand Lift
☐ *Mechanical Sit to Stand Lift
☐ *Power Floor Lift
☐ *Free standing Ceiling Lift and Track - 2 post
☐ *Bariatric Free Standing Ceiling Lift and Track
*Sling types: ☐ Quickfit/Universal ☐ Hygiene ☐ Hammock
☐ Band Sling ☐ Repositioning ☐ Tri-turn
*Sling Size: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ Bariatric

**POSITIONING/TRANSFER AIDES**
☐ Bed Assist Handle
☐ Transfer Board
☐ *Trapeze ☐ Attaches to bed ☐ Free Standing ☐ Bariatric

**OTHER:** ☐ IV Pole ☐ Bed cradle

**Additional Equipment (Private vendors only):**

**Clinician Signature:** _____ **Print Name:** _____
**Contact phone:** _____ **Date:** _____
***A STERISK IDENTIFIES ADVANCED EQIUPMENT**

## APPENDIX E: Extension Form

### MEDICAL EQUIPMENT PROVISION PROGRAM
### EXTENSION FORM

**Client Referring Health Authority:** ☐ FHA ☐ IHA ☐ NHA ☐ PHSA ☐ VCH ☐ PHC ☐ VIHA
**Client Home Health Authority:** ☐ FHA ☐ IHA ☐ NHA ☐ PHSA ☐ VCH ☐ PHC ☐ VIHA
☐ Acute Care ☐ Community Health Services ☐ Health Authority Clinic ☐Other _____

**STEP 1: Client Information**

**Client:**
Last Name: _____ First Name: _____ Middle Initial: _____

PHN Number: _____ Birth Date (DD/MM/YY) _____

Address: _____ City: _____ Postal Code: _____ Phone: _____

**Alternate/Caregiver Name:** _____ Phone Number: _____

**Step 2: Equipment Extension**

Original Rental Due Date: _____

List Equipment to be Extended: _____

New Rental Due Date: _____

Is your Equipment Rental extension based on a long-term need (> 6mths) (FH & VCH/PHC only)? ☐ Yes ☐ No

If **Yes**, proceed to Step 3: Authorization section.

To be eligible for up to a 3 month extension of the equipment rental, the following criteria must be met:

☐ The absence of equipment pose a significant risk of injury to the caregiver or client
AND, one of the following:

☐ Client has been approved for equipment by another organization/program and is waiting for its arrival within the next 3 months.

- Funding Organization name: _____
- When is equipment expected: _____
- Date referral initiated: _____

☐ Client is waitlisted for a facility.

- Date Facility process initiated: _____
- Estimate of time before placement: _____

☐ Client is registered with BC Palliative Care Benefits Program

Other Reason: _____

**Step 3: Authorization**

☐ Extension Authorized ☐ Extension NOT Authorized ☐ Long-Term Funding Authorized (>6mths) (FH & VCH/PHC only)

Client/Representative Name: _____

Client/Representative Signature: _____

☐ Client/Decision Maker provides verbal consent
Health Care Professional Name Print: _____ Signature: _____

Manager/Designate Approval Name Print: _____ Signature: _____

**Vendor Name:** _____ **Vendor Fax Number:** _____

**Instructions**: Health Care Professional to complete this form. Form faxed to vendor. Copy to Client.

***Note*** - Extension form is for Health Authority Clients who have previously approved Health Authority funded equipment

****Last page of document****

| | | | |
|---|---|---|---|
| **First Issued:** | (e.g. 05-MAR-2016) | | |
| **Approving Body:** | | | |
| **Final Sign Off:** | **Name** | **Title** | **Date Signed** |
| | | e.g.<br><br>Director – Professional Practice | DD-MMM-YYYY |
| **Developed By:** | **Name** | **Dept.** | **HO** |
| | Sara Camano | PEIPP | PHSA – BC Cancer |
| | | | |
| | | | |
| **Owner(s):** | e.g. name, title/position | | |
| | | | |
| **Posted Date:** | DD-MMM-YYYY | | |
| **Version:** | | | |
| **Revision:** | **Name of Reviser** | **Description** | **Date** |
| | Ryna Levy-Milne | Added that the scope was for BC Cancer dietitians and physiotherapist. | 06-12-2019 |
| | | | |
| | | | |