

PARTS CHANGE/ REPAIR REQUEST

Note: Illegible or incomplete forms will be returned to the prescriber

ALL REPAIRS COMPLETED AT 1857 NOTRE DAME AVE ARE DONE BY APPOINTMENT ONLY

CLIENT DEMOGRAPHICS				
FIRST NAME		LAST NAME		
DATE OF BIRTH (MM/DD/YYYY)	GENDER male female		PHIN	
HOME ADDRESS	CITY		POSTAL CODE	
HOME PHONE	CELL PHONE		EMAIL	
PRESCRIBER				
POSITION <input type="checkbox"/> OCCUPATIONAL THERAPIST <input type="checkbox"/> PHYSIOTHERAPIST <input type="checkbox"/> OTHER: _____				
FIRST NAME		LAST NAME		
ADDRESS	CITY		POSTAL CODE	
EMAIL	PHONE		FAX	
THIRD PARTY FUNDING INFORMATION				
<input type="checkbox"/> EMPLOYMENT & INCOME ASSISTANCE Case Number: _____		<input type="checkbox"/> NON INSURED HEALTH BENEFITS 10-digit number: _____		
DESCRIPTION OF REQUEST				
Repair to be completed:	<input type="checkbox"/> In hospital <i>Provide details below</i>	<input type="checkbox"/> In client's home	<input type="checkbox"/> Workplace /school/ day program <i>Provide address below</i>	<input type="checkbox"/> SMD Wheelchair Services <i>(1857 Notre Dame Ave; by appointment only)</i>
Please provide address/details if repair is to be done outside of client's home:				
Describe the issue client is experiencing with their chair:				
What repairs are required AND/OR what parts require inspection/ replacement?				