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| **TO:** | | |
|  | **FOURNISSEUR** | **TÉLÉCOPIEUR** |
|  | Embracor Medical | 506-854-2548 |
|  | Harding Medical, Moncton | 506 855-5113 |
|  | Lawtons Home Health Care, Moncton | 506-855-1838 |
|  | Lawtons Home Health Care, Saint Jean | 506 657-9742 |
|  | Ortho M L | 506-759-1094 |
|  | Restair | 506 684-5345 |
|  | Tango Medical, Fredericton | 506 452-7449 |
|  | Tango Medical, Moncton | 506 855-8843 |
|  | Tango Medical, Saint John | 506 634-7404 |

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| **RENSEIGNEMENT SUR LE CLIENT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nom du client | | | | |  | | | | | | | | | | | | | | | | | | No de téléphone | | | | | | | | | |  | | | | | | | | |
| Adresse complète: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No de la carte de santé | | | | |  | | | | | | | | | | | | | | | | | | Date d’expiration: | | | | | | | | | |  | | | | |  | | |  |
|  | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | JJ | | | | | MM | | | AAAA |
| **RENSEIGNEMENTS DE LA DEMANDE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date:** | JJ | | | MM | | AAAA | |  |  | **URGENTE** | | | | | | | | | | | | | | | | | | |  | | | | | **PAS URGENTE** | | | | | | | |
|  | | |  | |  | |
|  | Équipement d’évaluation | | | | | | |  | | Devis | | | | | | | | | |  | | | | | Demande modifiée  Date: | | | | | | | | | | | | | | | | |
| Équipements similaires acceptables pour les articles demandés ci-dessous? | | | | | | | | | | | | | | | | | | | | | | | | Demande de partage des couts? | | | | | | | | | | | | | | | | | |
|  | Oui (*Téléphoner pour en discuter avec le thérapeute.)* | | | | | | | | | | | | | | | |  | | Non | | | | |  | | | Oui | | | | | | | | |  | | | Non | | |
| **Spécifications du fauteuil roulant** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fauteuil manuel | |  | | | Pliant | | | | | | | |  | | | Rigide | | | | | | | | | | | | | | |  | | | | À bascule | | | | | | |
| Nom du modèle: | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Standard | | | | | | |  | | | Hémi | |
| Fauteuil motorisé | |  | | | Roues motrices avant | | | | | | | |  | | | Roues motrices centrale | | | | | | | | | | | | | | |  | | | | Roues motrices arrière | | | | | | |
| Nom du modèle: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Positionnement motorisé: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Assistance motorisé: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Type de commande: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Taille du fauteuil | | Largeur du siège: | | | |  | | | | | | | | | | | | Profondeur du siège: | | | | | | | | | | | | | | | | | | | | | | | |
| Hauteur siège-sol: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Avec le coussin | | | | | |  | | | Sans le coussin | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type d’appui-pieds: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Longeur de la jambe: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coussin | | Taille: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type de coussin: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2ëme housse de coussin demandé? | | | | | | | | | |  | | | Oui | | | | | |  | | | | | Non | | | | | | | | | | | | | | | |
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| Nom du client | | |  | | | | | | | | | | | | | | | | | | | No de la carte : | | | | | | | | | |  | | | | | | | | | |

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| Dossier | Largeur: | | Hauteur: |  |
| Modèle: | | | |
| Arms | Style: | | | |
| Hauteur: | | | |
| Roues | Roues avant: | | | |
| Arrière: | | | |
| Type de pneu: |  | | |
| Type de cerceau: |  | | |
| Freins |  | | | |
| Accessoires de positionnement |  | | | |
| Autres / Information de montage et de livraison |  | | | |

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| **Équipement de convalescence** | |
| Type d’équipement | Spécifications: (marque/taille/caractéristiques) |
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| **RENSEIGNEMENTS SUR LE THÉRAPEUTE** | | | | | | | | |
| Nom: |  | | | Location: | |  | | |
| Téléphone |  | | | Télécopier: | |  | | |
| Courriel |  | | | | | | | |
| Méthode de communication préférée: | |  | Courriel |  | Téléphone | |  | Un ou l’autre |