Comfort Mobility
Home Health Care

2707 Temple Drive, Windsor (Off Central just North of EC Row)
Hours: Mon - Fri 9:00AM – 4:00PM **www.comfortmobility.ca**

E-mail to Comfort Mobility | Print Form | Clear Form

HEALTHCARE REFERRAL FORM

E-mail, Fax, or bring in this form to Comfort Mobility
info@comfortmobility.ca
Phone 519-988-1234 Fax 519-988-1244

CLIENT INFORMATION

First and Last Name as per Ontario Health Card		Date
Street Address		
City	Province	Postal Code
Green Shield Number (Comfort Mobility can direct bill)	Date of Birth (YYYY/MM/DD)	Height Weight

REFERRING HEALTHCARE PROVIDER

Name		Title
Address	City	Postal Code
Phone Number	E-mail Address	

EQUIPMENT

□ Rental (not all items listed are for rent) □ Purchase

Bathing & Dressing

Shower/Bath Chair
□ No Back □ With Back
□ With Back & Arms
□ Bariatric □ Any Available

Tub Transfer Bench
□ Standard □ Padded
□ with Curtain Guard

□ Tub Rail □ Bath Lift

□ Reacher, Length: _____"

□ Shoehorn □ Leg Lifter
□ Sock Aid □ Other: _____

Compression Socks
□ 8-15 mmHg (diabetic)
□ 15-20 mmHg (OTC)
□ 20-30 mmHg □ 30-40 mmHg
□ 40+ mmHg

□ Calf □ Thigh □ Pantyhose
□ Chaps □ Maternity □ Arm sleeve
□ Glove □ Gauntlet □ Left □ Right

# of Pairs: _____

Electric Lift Chair
□ 3-Position (Std) □ Trendelenburg
□ Tilt in Space □ Heat/Massage
Client Height & Weight: _____

Toileting & Incontinence

Commode
□ Standard □ Bariatric
□ Drop Arm □ Wheeled
□ Bucket □ Splash Guard

Raised Toilet Seat
□ Standard □ Elongated
□ 2" Rise □ 3" Rise
□ 6" Rise □ With Arms

□ **Versa Frame**

Grab Bar(s)
Size(s) □ 12" □ 16" □ 18"
□ 24" □ 32" Custom_____"
Location:
_____

_____

Incontinence Supplies

□ Pull Ups □ Tabs/Briefs
Absorbency: □ Regular
□ Overnight □ Ultra/Super
Waist Measurement: ___"

□ Wipes □ Barrier Cream
□ Cleansing Cream
□ Guards □ Pads/ Liners

Under pads
□ Disposable □ Reusable

Mobility Aids & Bracing

Cane
□ Single Point □ Mini Quad
□ Sm Quad □ Lg Quad

□ Crutches

Walker
□ No Wheels
□ Two Wheeled

□ **Rollator**
□ Standard □ Bariatric
Seat Ht: □ 18" □ 21" □ 24"
Handle Height: ____"

Bracing
□ Ankle □ Knee □ Wrist
□ Back □ Elbow □ Thumb

Diagnosis/Instructions:
_____

_____

_____

_____

Rehab Supplies for:
□ Hip Replacement
□ Knee Replacement
□ Other: _____

Wheelchairs

□ Transport □ Manual
□ Tilting □ Power

Seating
□ Foam □ Gel □ Air (Roho)
Width: _____" Depth _____"

□ To be accessing Assistive Devices Program (ADP)

Provider Notes or Other Equipment not listed:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I am a health care professional, acting within my scope of practice, and have the authority to recommend the identified equipment.
Provider Initials _____ This equipment is required for □ Short-term basis (less than 90 days) □ Long-term basis

In my professional judgement, the above-named client can safely use the identified equipment.
□ I will provide and/or have provided training to client/caregiver.
□ Client can use independently without additional training. Provider Signature: _____