 <p>Winnipeg Regional Health Authority Office régional de la santé de Winnipeg Caring for Health À l'écoute de notre santé</p> <p>COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE</p>	Form Name: REQUEST FORM FOR HOME CARE: ELECTRIC BEDS, MATTRESSES, OVERBED TABLES & BEDRAILS	Form Number: WCC-00314
	Guideline Approved By: Home Care Program	Pages: 1 of 2
	Approval Date: August 2020	Supersedes: WCC-00157 Electric Bed Assessment Tool WCC-00179 TSS Transfer Form WCC-00178 Request for TSS WCC-00180 TSS Functional Information Form

1.0 Form Purpose:

- 1.1 Ensure client is eligible for Home Care electric beds, bedrails, overbed tables, and therapeutic support surfaces/mattresses. The form will assist Regulated Health Professionals with selection of appropriate equipment by embedding clinical criteria in request form.

2.0 Definitions:


- 2.1 Therapeutic Sleep Surface: also referred to as TSS or Support Surface is a specialized device for pressure redistribution designed for management of tissue loads, micro-climate, and/or other therapeutic functions (i.e. any mattresses, integrated bed system, mattress replacement, overlay, or seat cushion, or seat cushion overlay).” (National Pressure Ulcer Advisory Panel, 2007, p. 1)
- 2.2 Regulated Health Professional- a licensed health care professional who is registered by an appropriate regulatory body.

3.0 Used By:

- 3.1 Must be completed in full by a Regulated Health Care Professional or Community Case Coordinator with experience in assessing clients for home care equipment.

4.0 Guidelines for Completion:

- 4.1 Complete demographics in upper right-hand corner or use community client label.
- 4.2 Indicate date client assessment was completed and whether a home visit was done.
- 4.3 Complete client phone number.
- 4.4 Indicate client’s diagnosis.
- 4.5 Indicate client height and weight
- 4.6 Section 1 – Home Care Electric Bed
 - 4.6.1 Indicate if client requires an electric bed frame.
 - 4.5.2 Check all boxes that apply to determine eligibility and provide rationale for each checked box.
 - 4.6.3 Indicate width of bed frame needed
 - 4.6.4 Indicate height range of bed frame needed.
 - 4.6.5 Indicate if bed extension is required.
- 4.7 Section 2 – Mattress Selection
 - 4.7.1 Check one box only to indicate category of mattress needed.
 - 4.7.2 Indicate whether client has excessive sweating.
- 4.8 Section 3 – Overbed Table
 - 4.8.1 Indicate if overbed table is needed.

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4.8.2 Check all boxes that apply to indicate eligibility criteria

4.9 Section 5 – Bed Rails

4.9.1 Indicate whether bed rails are required.

4.9.2 Indicate reason bed rails are required.

4.10 Complete assessor's name, signature, phone number, and work site.

4.11 If client has a Case Coordinator and assessor is not the Case Coordinator, indicate the date that Case Coordinator was notified of request.

5.0 Filing/Routing Instructions:

5.1 Fax this document along with the Community Health Services Equipment or Supply Order Script to the Program Consultant for approval at (204) 940-6620.

5.2 If requesting alternating air mattress or low air loss cover then the Braden Scale (WCC-00282) must be faxed along with the document and the Community Health Services Equipment or Supply Order Script.

5.3 Hospital Based Case Coordinators/Community Case Coordinators/Therapy Only/Nursing Resource Coordinators/Equipment Only Senior Administrative Assistant should scan and upload document in Electronic Home Care Record Documents.

6.0 Printing Instructions:

6.1 Community Standard – White bond paper, black ink, two-hole top punch, and head to foot (tumble print) for two sided forms.

6.2 Within WRHA, forms can be printed directly form INSITE.

7.0 Author:

Kim Baessler- Program Consultant Home Care Equipment, Supplies & Wheelchairs.