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Community Therapy
SERVICES

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Winnipeg, MB R3T 3K7
www.ctsinc.mb.ca
Facsimile: 204-942-1428
Téléphone: 204-949-0533

SPLINT/EQUIPMENT PRESCRIPTION

Name:_____
Surname First Name

Address:_____ Telephone Number:_____

P.H.I.N.:_____ D.O.B:_____

Diagnosis:_____

Insuring Company/Funder: _____

The above named client has been assessed by Community Therapy Services and requires the following equipment. If you agree, please sign below with registration number and return to the therapist.

EQUIPMENT
SUPPLIER:

Signature of Assessor:_____ Name printed:_____
(Occupational/Physiotherapist)

Date of Assessment:_____ Phone Number: _____

_____

Physician/Nurse Practitioner (Please Print):_____

Address:_____ Phone Number:_____

Signature of Physician/Nurse Practitioner: _____

Registration Number: _____