Client Name: ____________________
PHIN: ____________________
Address: ____________________
City/Postal Code: ____________________
Phone #: ____________________
Date of Birth (dd/mm/yyyy): ____________
MFRN (MHSC): ____________________
Gender: ____________________

(or use client label)

HOYER ADVANCE PORTABLE LIFT REQUEST FORM

(must accompany completed Lift Equipment Assessment Tool)

Date of Assessment (dd/mm/yyyy):______________________________

Materials Distribution Agency medical products catalogue description: Hoyer Advance unique swan-neck leg design allows the lift to get close to wide obstacles; 3.3" double front castors and 4" double rear castors; **weight capacity: 340 lbs.** Due to the configuration of the Hoyer Advance cradle, greater clearance may be achieved compared with the HPL 402 Power Lift. Folded dimensions are 17.7"height x 46.5"depth X 21.6"width and weighs total of 69 lbs or 31, 33 & 5 lbs for the 3 separate parts when dissembled.

Considerations and criteria for requesting Hoyer Advance Portable Lift:

- Standard Home Care Power Lift does not meet client needs
- Client requires a lift system that is portable from one environment to another
- Only slings compatible with the Hoyer Advance Portable Lift can be used with this model
- Client specific or equipment specific training is required for Home Care Attendants

The following must be completed when requesting Hoyer Advance Portable Lift:

Client's weight is less than 340 lbs. ☐ Yes ☐ No

Reasons for request /client's need:

☐ Social activities ☐ Medical appointment ☐ Work ☐ Travel/Leisure
☐ Standard Home Care Power Lift does not meet client needs
☐ Other ____

Anticipated frequency of use for transport purposes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Single use (planned trip)
☐ Other ____

Targeted outcomes: (check all that apply)

☐ Increase client independence / improve access to daily occupations
☐ Increase safety for: _____ Client ______Caregiver
☐ Other ____
☐ See completed Lift Equipment Assessment Tool for details

Operating, folding, lifting portable lift will be done by (check all that apply):

☐ Client/caregiver ☐ Home Care Staff ☐ Other ______________________

Client has caregiver(s) physically capable of operating, folding, lifting and loading portable lift?

☐ Yes ☐ No

Caregiver agrees to training in correct and safe use of lift system? ☐ Yes ☐ No

OT has assessed that client/caregiver has suitable vehicle to transport travel lift? ☐ Yes ☐ No

Type of vehicle: ______________________

Will Home Care staff be required to transport/move lift into vehicle? ☐ Yes ☐ No
If yes, client specific training is required.

OT Name/Signature: ______________________ **Phone:** ____________ **Fax:** ____________

CC Name/Signature: ______________________ **Phone:** ____________ **Fax:** ____________

Complete Lift Equipment Assessment Tool, WRHA Logistics Script and this form and forward forms to Case Coordinator (CC) for review. CC faxes to WRHA Home Care Program Consultant for approval at fax #: 940-2009.

Legend OT: Occupational Therapist CC: Case Coordinator