Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Community Therapy Services

Home Care Overhead Lift Request Form

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

Date of Assessment: D D M M M Y Y Y Y

Home Visit done: ☐ No ☐ Yes D D M M M Y Y Y Y

Client's Phone Number:

Client's Weight: _____ ☐ pounds ☐ kilograms **Client's Height:** _____ ☐ feet/inches ☐ centimetres

Relevant Health Issues: (e.g. Diagnosis, weight bearing status, prognosis) _____

WRHA Guidelines: When total lift equipment is needed, it is standard procedure to provide a floor lift. If an overhead lift system is being requested instead of a floor lift, justification must be provided. Home Care only provides an overhead lift for one room.

Environmental Considerations

Location: ☐ Bedroom ☐ Living Room ☐ Bathroom (Proceed directly to Bathroom section below)

Space: **Lack of floor space prevents safe use of a floor lift?** ☐ **No** ☐ **IF Yes; complete the following:**
Is the room too small? ☐ No ☐ Yes, indicate reasons why alternate spaces will not work: _____
Is the room cluttered? ☐ No ☐ If Yes, indicate why the room cannot be cleaned out: _____

Flooring: **Does unsuitable flooring prevent safe use of floor lift:** ☐ **No** ☐ **IF Yes; complete the following:**
Can the issue be rectified? (e.g. flooring repaired/replaced, carpet removed) ☐ No ☐ Yes
If no indicate why ☐ Lack of financial and/or family resources ☐ Client/Family Refusal ☐ Rental - Landlord Refusal
Is there another space with appropriate flooring that can be used? _____

Bathroom: Which transfers require the use of an overhead lift: ☐ Tub ☐ Toilet ☐ Both
Reason floor lift cannot be used for bathing: ☐ Tub not raised ☐ No wheel-in shower ☐ Inadequate floor space

Other: _____

Client/Care Plan Considerations

Floor lift is unsafe due to client's weight: (Note: weight of more than 250 pounds/113 kilograms may increase risk) ☐ No ☐ Yes
Comments: _____

Overhead lift may reduce number of staff/caregivers required for transfers: ☐ No ☐ Yes
Comments: _____

Overhead lift may reduce difficulties associated with client's level of pain, spinal deformity, spasticity, contractures, involuntary movements, cognition, and/or challenging behaviors: ☐ No ☐ Yes ☐ Not Applicable
Comments: _____

Overhead lift is required for the purpose of positioning client in order to facilitate safe client handling: ☐ No ☐ Yes

Other: _____

Ordering Instructions

Fax completed form to WRHA Home Care Program Equipment Consultant at 204-940-2009.

If a mounted system is being requested rather than the standard pressure fitted system, please provide rationale:

Ordering Details Sling Size/Type: _____
Safe Visit Plan in Place: ☐ Yes ☐ No
Safe Visit Plan Details: _____
Contact Information for Install: _____
Home Care Case Coordinator Notified: ☐ Yes ☐ No Name and Location: _____

Occupational Therapist: _____ Phone: ___-___-____
Worksite: _____

Signature: _____ Date: D D M M M Y Y Y Y

Equipment Approval Needed