Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg Caring for Health / À l'écoute de notre santé **COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE**	**Form Name:** HOME CARE REQUEST FORM: ELECTRIC BEDS, BEDRAILS, OVERBED TABLES, & MATTRESSES	**Form Number:** WCC-00314
	Approved By: Home Care Program	**Pages:** 1 of 2
	Approval Date: November 2022	**Supercedes:** WCC-00157Electric 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 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.

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 or Low Air Loss mattress or cover. 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.