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Community Therapy SERVICES

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Winnipeg, MB R3H 1B6
www.ctsinc.mb.ca
Facsimile: 204-942-1428
Téléphone: 204-949-0533

Veterans Affairs Canada Equipment Prescription and Authorization for Release of Information

Date: _____ Name: _____ K# _____

Home Address or PCH: _____ Phone # _____

Equipment Prescription:

Supplier: _____

Therapist's Signature: _____ Ext.: _____ OT ☐ PT ☐

Refer to benefit grids for requirement of physician's signature.

Physician's Signature: _____

Physician's Name: _____

Please take this prescription to a vendor of your choice to obtain your equipment.

I authorize the release of this information to the supplier named above. The information is to be used only for the purpose of applying for funding for the equipment named. This release is valid for 6 months from the date of authorization.

Signature: _____
Client or legal representative

Witness: _____

Date: _____