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

Home Care

Intermittent Pneumatic Compression Pump Assessment

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

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

An Intermittent Pneumatic Compression Pump is needed for the following reason:

☐ **Lymphedema**
Must be completed by Certified Lymphedema Therapist

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☐ **Gross Edema Related To Venous Insufficiency**
Must be completed by Home Care Clinical Nurse Specialist or Community Therapy Services Physiotherapist

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☐ **Amputee**
Must be completed by Health Sciences Centre Physiotherapy

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Plan for Monitoring:

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Plan for Equipment Retrieval:

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_____
ASSESSOR'S SIGNATURE

_____
ASSESSOR'S PRINTED NAME AND DESIGNATION

Assessor's Phone: ___-___-____ Assessor's Site: _____

If Case Coordinator involved, name and date that Case Coordinator was notified:

_____
PRINTED NAME

D D M M M Y Y Y Y

Fax Completed assessment along with ***Community Health Services Equipment or Supply Script Order*** to WRHA Program Consultant at 204-940-2009