Ministry of Social Development and Social Innovation

ORTHOSES
REQUEST AND JUSTIFICATION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act.* The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* Any questions about this information should be directed to your local Employment and Assistance Office.

PROGRAM OBJECTIVE: To provide the most basic, least costly orthoses to meet a medically essential need. Full details on eligibility criteria can be found on the ministry's Online Resource Policy Manual at: http://www.gov.bc.ca/meia/online_resource/

SECTION 1 – CLIENT INFORMATION (to be completed by worker)

CLIENT SURNAME	CLIENT GIVEN NAME	PHONE NUMBER	BIRTH DATE	PERSONAL HEALTH NUMBER [Care Card]

CLIENT STREET ADDRESS (IF RESIDENTIAL CARE FACILITY, NAME OF FACILITY)	CITY / TOWN	POSTAL CODE

1. IS CLIENT ELIGIBLE TO ACCESS MEDICAL EQUIPMENT UNDER THE EMPLOYMENT AND ASSISTANCE OR EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES REGULATIONS? ☐ YES ☐ NO

2. ARE THERE OTHER RESOURCES AVAILABLE TO PROVIDE THE REQUESTED ORTHOSIS? (for example, ICBC, WorkSafeBC, Veterans Affairs, private insurance) ☐ YES ☐ NO

PLEASE EXPLAIN:

SIGNATURE OF WORKER	OFFICE CODE/BRANCH	WORKER NUMBER	DATE SIGNED (YYYY MMM DD)

I HEREBY GIVE MY PERMISSION FOR ANY MEDICAL PRACTITIONER OR NURSE PRACTITIONER, HOSPITAL OR AGENCY TO GIVE ANY MEDICAL INFORMATION RELEVANT TO THIS APPLICATION TO THE MINISTRY OF SOCIAL DEVELOPMENT AND MY PERMISSION FOR THE MINISTRY OF SOCIAL DEVELOPMENT TO DISCUSS THIS REQUEST WITH THE EVALUATING PROFESSIONALS. THE ORTHOSIS RECOMMENDED HAS BEEN DESCRIBED TO ME AND I AGREE WITH THE RECOMMENDATIONS.

CLIENT SIGNATURE	DATE SIGNED (YYYY MMM DD)

SECTION 2 – MEDICAL OR NURSE PRACTITIONER RECOMMENDATION

DESCRIBE THE MEDICAL CONDITION OF YOUR PATIENT

WHAT TYPE OF ORTHOSIS IS RECOMMENDED?

IS A CUSTOM-MADE ORTHOSIS REQUIRED? ☐ YES ☐ NO

IF THE ORTHOSIS IS A KNEE BRACE, WILL IT BE REQUIRED AT LEAST 6 HOURS PER DAY? ☐ YES ☐ NO

SIGNATURE OF MEDICAL PRACTITIONER/NURSE PRACTITIONER	PHONE NUMBER	DATE SIGNED (YYYY MMM DD)

NOTE: IF CUSTOM ORTHOSIS REQUIRED, PLEASE REFER PATIENT TO AN ORTHOTIST, PEDORTHIST, PODIATRIST, OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST

ORTHOSES
REQUEST AND JUSTIFICATION

SECTION 3 – ASSESSMENT (TO BE COMPLETED BY ORTHOTIST, PEDORTHIST, PODIATRIST, OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST)

NOTE: PLEASE ATTACH A DETAILED QUOTE.

1. SPECIFICATIONS OF THE ORTHOSES REQUIRED TO MEET THE APPLICANT'S NEEDS.

2. PLEASE EXPLAIN HOW THE PRESCRIBED ITEM WILL ASSIST WITH JOINT MOTION AND/OR SUPPORT.

3. IS THE ITEM REQUIRED FOR ONE OR MORE OF THE FOLLOWING PURPOSES?

A. PREVENTION OF SURGERY	☐ YES	☐ NO
B. FOR POST SURGICAL TREATMENT	☐ YES	☐ NO
C. TO ASSIST IN PHYSICAL HEALING FROM SURGERY, INJURY OR DISEASE	☐ YES	☐ NO
D. TO IMPROVE PHYSICAL FUNCTIONING THAT HAS BEEN IMPAIRED BY A NEURO-MUSCULO-SKELETAL CONDITION	☐ YES	☐ NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN

4. IF THE ORTHOSIS IS A CUSTOM-MADE FOOT ORTHOTIC,
WILL IT BE MADE FROM A HAND CAST MOLD? ☐ NO ☐ **YES,** PLEASE EXPLAIN

5. IF THERE IS ANY OTHER INFORMATION THAT MAY BE RELEVANT TO THIS APPLICATION, PLEASE EXPLAIN. (FOR EXAMPLE, WHAT IS THE CONDITION OF THE CURRENT DEVICE?)

SIGNATURE OF PERSON PROVIDING CLINICAL TREATMENT	PRINT NAME	DATE SIGNED (YYYY MMM DD)
POSITION/TITLE	PROFESSIONAL REGISTRATION NUMBER (IF APPLICABLE)	

NOTE: Forward completed form to Ministry of Social Development and Social Innovation, Health Assistance Branch, P.O. Box 9971 STN PROV GOVT Victoria, BC V8W 9R5