Name:_____

Date of Birth: _____

PHIN:_____

Address:_____

Overhead Lift Request/Approval Form

Date of Assessment: _____
(Day/Month/Year)

Home Visit Done: ☐ No ☐ Yes **Date:** _____ **Client's Phone Number:** _____
(Day/Month/Year)

Client's Weight: _____ ☐ pounds ☐ kilograms **Client's Height:** _____ ☐ centimeters ☐ feet/inches
Relevant Health Issues: (e.g. Diagnosis, weight bearing status, prognosis)

_____

Care Provider (check all that apply): □ **SH-SS Home Care staff** □ **Family** □ **Family Managed Care**

Environmental Considerations

Location of Lift: ☐ Bedroom (Reason why Living room is unsuitable for floor-based lift)

☐ Living Room ☐ Bathroom (Proceed directly to Bathroom section below)

☐ Other: _____

Space: **Lack of floor space prevents safe use of a floor lift? ☐ No ☐ Yes; complete the following:**

Is the room too small? ☐ No ☐ Yes, indicate what other space(s) has been considered and why alternate spaces will not work: _____

Is the room cluttered? ☐ No ☐ Yes, indicate why the room cannot be cleaned out: _____

Flooring: **Does unsuitable flooring prevent safe use of floor lift: ☐ No ☐ 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 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 difficulties associated with client's level of pain, spinal deformity, spasticity, contractures, involuntary movements, cognition, challenging behaviors and/or frequent repositioning for management of skin integrity: ☐ 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:

Recommendations

☐ vendor quote attached ☐ equipment available through SH-SS equipment pool

☐ further client information/report attached

Ordering Details

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

Sling Size/Type:

Contact Information for install:

☐ Yes ☐ No Home Care Case Coordinator Notified Name and Location: _____

☐ Installation consent form completed and attached (for rental properties)

Occupational Therapist/Physiotherapist: _____ Phone: _____

Worksite: _____

Signature: _____ Date: _____

☐ Occupational Therapist/ Physiotherapist to forward to Manager, Health Services-Rehabilitation Services

Approval Process

☐ approved (if approved, communicate with Case Coordinator) ☐ denied

_____ _____

Manager, Health Services-Rehabilitation Services Signature Date

☐ Order new ☐ Equipment pool ☐ Waitlist ☐ Priority 1 ☐ Priority 2

_____ _____

Director – Rehabilitation Services Date