

Medical Equipment Order Form

Date (dd/mm/yyyy)	Order Frequency <input type="checkbox"/> One-Time Order <input type="checkbox"/> On-Call <input type="checkbox"/> On-Going (automatic) Repeats: _____ Expiry Date (dd/mm/yyyy) _____	Delivery Method <input type="checkbox"/> Winnipeg Courier <input type="checkbox"/> Federal Mail <input type="checkbox"/> Client Pickup <input type="checkbox"/> Bus	Order # W/O # Entered By
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Scriptor Information

RHA #	Name		
Phone	Fax	Email	
Office Location Address		City	Postal Code

Client Information

PHIN # (9-digit Health Number)	Name		
Phone		Date of Birth (dd/mm/yyyy)	
Resident Address (provide full address including postal code)			
Delivery Address (if different from Resident Address)			

Equipment Return/Transfer

<input type="checkbox"/> Equipment Return from PHIN #	Name
<input type="checkbox"/> Equipment Transfer from PHIN #	Name

Catalogue Products (if more space is needed, please use reverse)

SAP #	Quantity	U of M	Product Description

Special Instructions

Authorization

Name	Signature	Date (dd/mm/yyyy)
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