SUPPLEMENT B – BARIATRIC ASSISTANCE

Please complete this Supplement only if you indicate you need **Bariatric Assistance** on page 4 of the Application (Section IV, Service Needs).

In addition, a typed clinical/medical summary must be included with this form.

Bariatric care is considered for clients with weight >/= 250 lbs/113 kgs, and/or a BMI of approximately >/= 30 who potentially require special equipment and extra consideration when moving.

Applicant Name:		
Health Card (OHIP) #:		
Weight:	**Height:**	**B.M.I.:**
Family Physician:		**Phone:**
Primary Diagnosis (including date of onset):		
Other Medical Conditions:		
Medically Stable?	**YES** ☐ **NO** ☐	
Advance Care Directives:		

EQUIPMENT – please identify any equipment owned by/rented for use by the client.

☐ Bariatric bed	☐ Specialty air mattress	☐ Slider(s)
☐ High density foam wedge	☐ Bariatric Lift Chair	☐ Bariatric floor lift
☐ Stand Assist Lift/Sit Stand Lift		☐ Ceiling Track Lift
☐ Abdominal binder	☐ Bariatric Commode	☐ Bariatric Wheelchair
☐ Bariatric Walker	☐ Compression stockings	☐ Scooter
☐ Back-up Power source		

☐ Sling(s): ☐ supine ☐ transfer ☐ limb ☐ hygiene

Width of: Wheelchair _______________ Scooter _________________

Commode _______________ Walker _________________

NUTRITION -

Do you have any specific nutrition needs? YES ☐ NO ☐
If YES, please provide details:

Have you been prescribed a specific diet? YES ☐ NO ☐
If YES, please provide details:

LEVEL OF PERSONAL CARE ASSISTANCE -

Are you able to:

- Lift your upper body independently? YES ☐ NO ☐
- Boost yourself up in bed independently? YES ☐ NO ☐
- Sit up from a lying position independently? YES ☐ NO ☐
- Stand from a sitting position independently? YES ☐ NO ☐
- Raise your arms independently? YES ☐ NO ☐
- Raise your legs independently? YES ☐ NO ☐

In your opinion, how many individuals are required to assist you with:

- Transfers ____________________
- Bathing ____________________
- Toileting ____________________
- Bed Mobility _________________

Date of last Occupational Therapist's Assessment: ________________________________

Date of last Respiratory Therapist's Assessment: _____________________________