Home Hospital Bed and Pressure Relieving Surface Assessment Form

This assessment form should be used to recommend hospital bed coverage under the Non-Insured Health Benefits Program. It must be completed by a physician, nurse practitioner, occupational therapist, physiotherapist or homecare registered nurse, and is considered a prescription or recommendation. Benefits covered and their eligibility criteria can be found on the Medical Supplies and Equipment Guide and Benefit Lists at canada.ca/nihb-medical-supplies-equipment > medical supplies and equipment guide and benefit lists.

Section A *(Check only if applicable)*

☐ Palliative Care Client
☐ Client is in a health care facility* – discharge date: (YYYY-MM-DD)
☐ Urgent If urgent, please explain:
☐ Client lives in a residential facility (e.g. LTC, PCH, other) AND the benefit is not covered for residents of the facility (written confirmation required)

NIHB only covers equipment for the client's place of primary residence only.

Section B Client Information (*Please print Illegible or missing fields will cause delays*)

Surname:	Given Names:
Client Address:	Client Phone Number:
Date of Birth: (YYYY-MM-DD)	Client ID#:

The Client Identification Number may be one of the following:

- Ten (10) digit Indian Act registration number (also known as Treaty or Status number) for eligible First Nations clients.
- Alpha prefix followed by an eight (8) digit number issued to certain registered First Nations and recognized Inuit clients by NIHB.
- Three (3) digit band number, followed by the five (5) digit family number identifying the family unit within the eligible First Nations client's band.
- Health plan number issued to recognized Inuit clients by the Governments of the Northwest Territories and Nunavut.

Section C Medical information

Height: ○ cm ○ ft. in. Weight: ○ kg ○ lbs

Diagnoses:

Section D Functional Assessment (*Check all that apply*)

Vision or Hearing Impairment:

○ Not applicable
○ Yes (please describe):

Cognition:

○ Intact
○ Impaired (please describe):

Communication:

○ Verbal
○ Non Verbal
○ Augmentative and Alternative
○ Communication device
○ Able to direct care
○ Unable to direct care

Mobility:

☐ Bedbound
☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent
☐ No Aid
☐ Cane
☐ Crutches
☐ Standard/2-wheeled walker
☐ 4-wheeled walker
☐ Wheelchair

Bed Mobility/Positioning:

☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent
☐ No Aid
☐ Rail(s):
○ 1 ○ 2
☐ Lift/sliding sheet
☐ Trapeze
☐ Mechanical lift and sling

Bed Transfers:

☐ Bedbound
☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent
☐ No Aid
☐ Rail
☐ Transfer belt
☐ Transfer pole
☐ Transfer board
☐ Trapeze
☐ Mechanical lift and sling
☐ Other:

Toileting:

☐ Completed in bed
☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent

Incontinence:

☐ N/A
☐ Bladder
☐ Bowel
☐ Catheterized

Bathing:

☐ Completed in bed
☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent

Feeding:

☐ Completed in bed
☐ Feeding tube
☐ Total Parenteral Nutrition (TPN)
☐ History/risk of aspiration
☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent

Dressing:

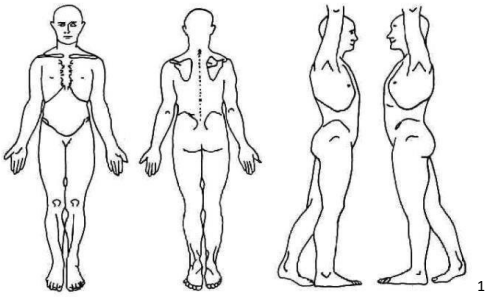
☐ Completed in bed
☐ Independent
☐ Independent with aids
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent

Grooming:

☐ Completed in bed
☐ Independent
☐ Assist (Nbr of people)
○ Min ○ Mod ○ Max
☐ Dependent

Skin Integrity:

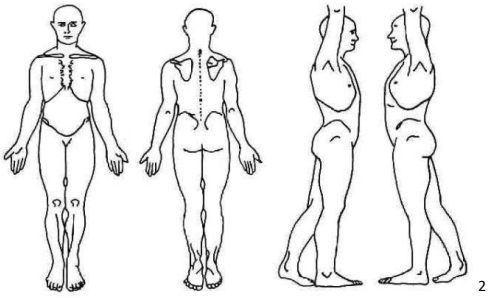
Areas of decreased sensation (please circle):



1

☐ Not applicable

Wound location (please circle):



2

☐ Not applicable

Wound Care:
○ Not applicable
○ Completed in bed
Frequency:

Wound Size(s):

Wound Stage:
○ Stage 1
○ Stage 2
○ Stage 3
○ Stage 4

Braden Scale Score:

History of wounds:
○ Yes
○ No
Location(s):

Nutritional deficiency that negatively impacts skin integrity or healing
○ Yes
○ No
Please describe:

Other risks:
☐ Diastolic pressure less than 60 mm Hg
☐ Anemia
☐ Smoking history

Amount of time spent in bed each day:

Client requires head of bed elevation due to:
☐ Not applicable
☐ Respiratory impairment
☐ Aspiration Risk
☐ To offload pressure from wounds or due to risk of skin breakdown
☐ Other:

A positioning wedge has been trialed:
○ Yes ○ No Outcome:

Client requires foot of bed elevation due to:
☐ Not applicable
☐ Lower extremity edema
☐ To offload pressure from wounds or due to risk of skin breakdown
☐ Other:

A positioning wedge has been trialed:
○ Yes
○ No Outcome:

1 School of Physiotherapy, University of South Australia. (n.d.). *Clinical Reasoning Reflection Form*. 1-15. Retrieved November 26th, 2020. https://cdn.ymaws.com/www.ipta.org/resource/resmgr/Treatment_of_Musculoskeletal/CRForm_-_long.pdf.

2 Ibid.

Section E Equipment Recommendation				
Bed	◯ Bed not required ◯ Rental ◯ Purchase	◯ Electric Hospital Bed ◯ Bariatric Electric Hospital Bed (equipment required for): ☐ weight capacity ☐ size ◯ Long Hospital Bed (84" - only available to clients whose height cannot be accommodated in a standard length bed)		Make: Model:
Rails	*(Must be compatible with recommended bed)*	◯ Rails not required ◯ Rental ◯ Purchase	◯ Assist rails ◯ Partial/half rails ◯ Full rails	Number of Rails ◯ 2 ◯ Other (please explain)
Mattress	◯ Mattress not required ◯ Rental ◯ Purchase	◯ Standard hospital bed mattress ◯ Bariatric hospital bed mattress ◯ Pressure relief hospital bed mattress ◯ Bariatric pressure relief hospital bed mattress		Make: Model:
Overlay	◯ Overlay not required	◯ Non-Powered Overlay ◯ Powered Overlay		Make: Model:
Length of time bed and mattress or overlay required: Equipment has been trialed ◯ Yes ◯ No Outcome:				
Additional Components Required or Additional Information to support application:				

Note: Rationale must be provided for equipment with price exceeding NIHB unit price.

Section F Home Assessment

A home assessment was completed on (*date*) , and I attest that the home can accommodate the delivery and use of the hospital bed recommended (*please initial*) .

OR

A home assessment was not completed however (name), (relationship to client) has measured the home (including door widths) and indicated that the home can accommodate the delivery and use of the hospital bed recommended (*please initial*) .

Section G Health Professional Information (*Please print*)	***Form must be dated and signed*
Surname:	Given Name(s):
◯ Physician ◯ Nurse Practitioner ◯ Homecare Registered Nurse ◯ Physiotherapist ◯ Occupational Therapist	
Licence Number: (Provided by your regulatory body)	Office Name/Location:
Phone Number:	Email:
Signature	Date (YYYY-MM-DD):

Privacy statement:

The personal information you provide to Indigenous Services Canada (ISC) is governed in accordance with the Privacy Act. We only collect the information needed to administer the NIHB Program. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal Information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at https://www.tbs-sct.canada.ca/ap/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.