Indigenous Services Canada / Services aux Autochtones Canada — Canada

Medical Supplies and Equipment Form

Date: ______________________

Completed By: ______________________

NOTICE TO RECIPIENT OF HEALTH INFORMATION

As required by Section 42 of the *Health Information Act*, the individually identifying diagnostic, treatment and care information being disclosed to you by our agency is being disclosed to you under the authority of the *Health Information Act*. The health information being provided to an individual who is responsible for providing continuing treatment and care to the individual who is the subject of the information as per Sec. 35(1)(b). This information can only be used for the purposes of providing health services (including obtaining payment for these services) for the individual who is the subject of this information.

Client Information: (Complete all information clearly. Illegible or missing fields will cause unnecessary delays. Thank you!)

Client's Surname:	Date of Birth: D D / M M / Y Y
Given Names:	Gender: M ☐ F ☐
Client DIAND #:	AB Health #:

Recommended Items (detailed information, product, size, quantity, etc.)

☐ Bariatric Client

Ht. ___________

Wt.___________

Registered Nurse Recommender:

Name (please print):	Community:
Telephone: Fax:	Email:
Signature:	CARNA Permit No.:

Preferred Vendor:

1st Choice: Name of Vendor (please print):	
Telephone:	Fax:

ONCE COMPLETE FORWARD TO: NIHB 780-495-3184 or HCC 780-495-2687