

Specialist Sling – Prescription Form

Date of Order / Enquiry..... / Official PON / Requisition Number.....

Customer Details

Name:.....

Address:.....

Telephone:.....

E mail:

End User / Patient Details (confidentiality is assured)

Name:

Address (if applicable).....

Telephone:.....

E mail:

01495 740070

Evergreen Supplies Ltd, Unit 15 Polo Grounds Ind Est
New Inn, Pontypool, Torfaen, NP4 0TW
sales@evergreensupplies.co.uk fax: 01495 740080



Age:.....

Height (cm of feet & inches – please denote):.....

Weight (kgs or stones – please denote):.....

Incontinent – Yes / No

Head Support Required – Yes / No.....

Toilet sling design required – Yes / No.....

Skin Integrity / Condition /Pressure Ulcer Consideration (Grade of Ulcer etc).....

Specialist fabric required (please select and circle from the following) – Black padded breathable spacer fabric, solid grey polyester, grey, breathable polyester mesh, lightweight, quick drying parasilk material, quilted grey, polyester padding.

Other fabric requested (please state).....

Current Hoist Selection in use (make and model).....

Type of spreader bar / hoist connection point (loops or clips) / lifting mechanism etc.....

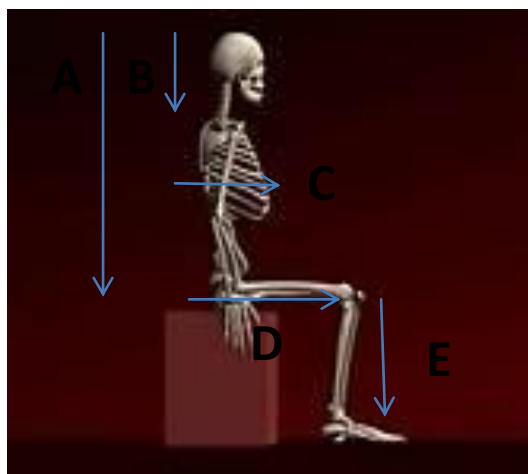
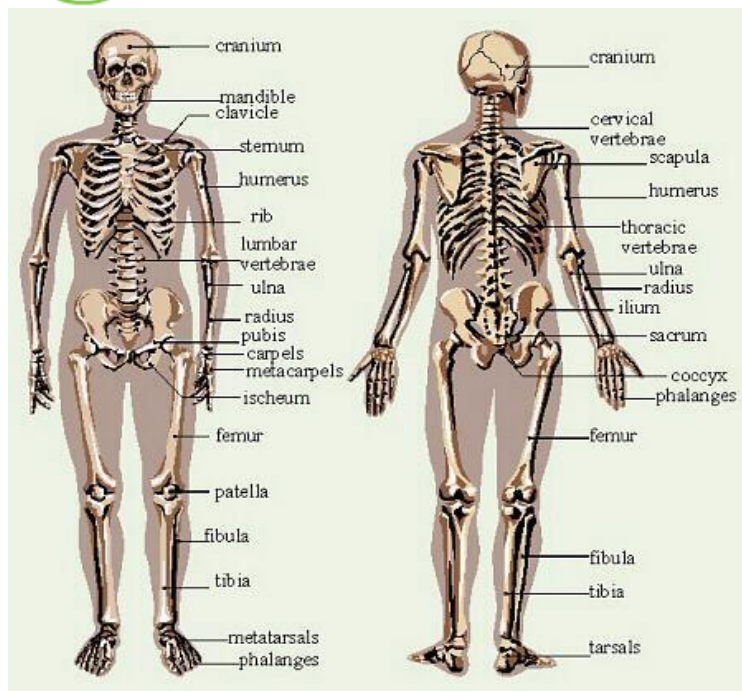
Belt required Yes / No (consider disability / patient stability whilst lifting)

Amputee Yes / No (please state single left leg - above or below knee – limb dimensions / bi lateral etc.).....
...

Clinical Considerations.....
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.....
.....

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Patient / End User Skeletal / Body mass Dimensions (in cm)

A) Top of head to base of spine.....

B) Top of head to base of neck.....

C) From Back to Front of Chest (Body mass).....

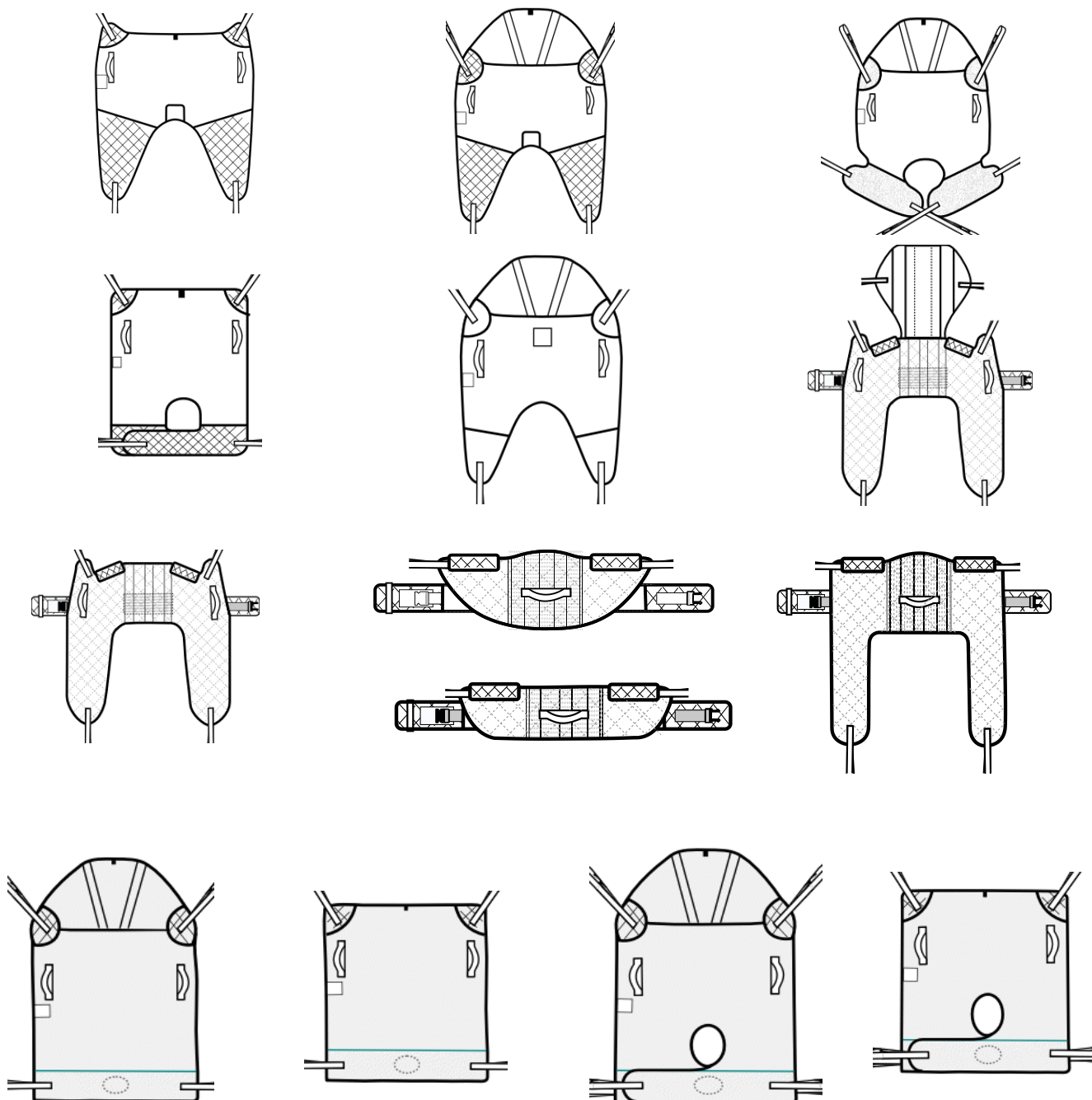
D) From Coccyx (base of spine) to Knee.....

E) From top of knee to heel base.....

Additional Notes:

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Please circle preferred choice or contact customer services for advice on telephone number:
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Notes:

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