Assistive Technology

PRODUCTS AND SERVICES

Communication Devices Program

Voice Amplifier Prescription Form

Deer Lodge Centre (DLC)
2109 Portage Ave.
Winnipeg, MB R3J 0L3
Phone: (204) 831-3430
Fax: (204) 885-2524

Date: D D | M M M | Y Y Y Y

FOR OFFICE USE ONLY
Received: D D | M M M | Y Y Y Y

1. CLIENT INFORMATION	
Client Last Name:	Client First Name:
Date of Birth: D D | M M M | Y Y Y Y	Personal Health Identification Number (PHIN):
2. PRESCRIBER INFORMATION	
Speech-Language Pathologist (SLP) Name:	Employer:
SLP primary phone/ fax:	SLP email:
Duration of involvement with client:	Ability to follow the client every 6 months: Yes / No
Occupational Therapist (OT) Name:	Employer (if different from SLP):
OT primary phone/ fax:	OT email:
Duration of involvement with client:	Ability to follow the client every 6 months: Yes / No

4. EQUIPMENT SELECTION	
Voice Amplifier Selected: *include headset style and any additional equipment required	
Name and signature of SLP Assessor and Device Prescriber:	_____ _____ Printed Name SLP Signature * Date:_____
Name and signature of OT Assessor and Device Prescriber:	_____ _____ Printed Name OT Signature * Date:_____

** It is my professional opinion that this individual meets the eligibility requirements for the CDP and that the prescribed equipment is the best option available at this time.*

PRESCRIPTION APPROVAL (CDP Internal Use)

Prescription Reviewed By:

_____ _____ Date Approved:_____
SLP Printed Name SLP Signature

_____ _____ Date Approved:_____
OT Printed Name OT Signature