Client/Customer____
Address:____
____
Equipment Provided:____

Housing Type: Apartment Single Story Multiple Story Mobile Home
Comments:____

Floor Surfaces: Carpet Linoleum Tile Hardwood Other:___________
Comments:____

Space: Open Small Rooms Hallways
Comments:____

Rooms Accessible: Bedroom Bath Living/Family Room Dining/Kitchen
Comments:____

Accessibility: Entry Door ___ Bathroom___ Kitchen___ Bedroom ___
Hallways ___ Ramps ___ Steps ___ Threshold ____

Safety Issues Noted:____
____
Grounded Plugs:________________

Client and/or Caregiver/Family Member is willing and able to use the equipment provided safely and adequately to assist with MRADL's in the home and to meet Medical Necessity Criteria and the limitations are sufficiently resolved with equipment provided: Yes _____ No ______

Client/Caregiver's Signature:____________________________ Date:_______

Delivery Technician's Signature:_________________________ Date:_______

Prescribing Physician's Signature:________________________ Date:_______