



1155 Notre Dame Avenue Winnipeg MB R3E 3G1

ASSISTIVE TECHNOLOGY REQUISITION

DATE:	mm/dd/yy
PATIENT'S NAME:	DATE OF BIRTH:
PARENT(S)/GUARDIAN:	PHONE NUMBER:
DIAGNOSIS	
CURRENT FUNCTIONAL STATUS	
Check all that apply: ☐ Appointment required (Assessment) ☐ Notify therapist of appointment ☐ List details below to build/modify equipment (Please provide as much detail as possible) ☐ Equipment to be picked up from school/daycare: ☐ Pick up address:	
DESCRIPTION	
Once completed, equipment(s) will require (Check of Fitting appointment Pick-up by	nnipeg)
Therapist Name: Therapist Phone Number: Therapist E-mail Address:	