Ministry of Health and Long-Term Care

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

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Statement of Support for Device Listing

Pressure Modification Devices

Section 1 – Device Information

Name of Device

Description of the Device

Model	Name of Manufacturer	Name of Distributor

Section 2 – Device Assessment

1. For how long have you used this product with your clients?

2. Do you find that this device is effective in managing lymphedema?

☐ Yes ☐ No

3. Have you or your clients experienced any problems with this device?

☐ Yes ☐ No

If yes, please describe these problems:

4. Describe your experience with this device in the management of lymphedema.

5. Is this device similar to others funded by the Assistive Devices Program?

☐ Yes ☐ No ☐ Don't know

If yes, please identify the generic codes or specific products.

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If no, please indicate reason(s) for the dissimilarity.

If not familiar with the ADP, describe other similar devices used for lymphedema management.

Section 3 – Authorizer/Therapist Information

PLEASE PRINT

Authorizer's Last Name		Authorizer's First Name
ADP Authorizer number	Telephone No. (include area code)	Fax No. (include area code)
Authorizer's Signature		Date (yyyy/mm/dd)

If you are not an ADP registered authorizer, please provide the following information:

Last Name	First Name
Profession	Years of Experience in Treating Clients with Lymphedema
Place of Employment	
Telephone No. (include area code)	Fax No. (include area code)
Signature	Date (yyyy/mm/dd)

PLEASE NOTE:
This form is intended to identify potential products for ADP funding.
It does not constitute an endorsement of the product.