



Ministry of Health
and Long-Term Care

Assistive Devices Program (ADP)
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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
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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.

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.