

Prescription Form

Funder: _____ Date: _____

Client: _____ Therapist: _____

Organisation: _____

Client Specific Needs

Specific medical condition (if applicable): _____

Other Requirements: _____

Are they self transferring from a wheel chair? Yes No

Do they need a hoist transfer? Yes No

Client weight kg: _____

✓ Tick Bed Options

✓ Tick Width cm

Please view www.mortonperry.co.nz or our catalogue for specifications

Homecare 90 110 135 150 Custom: _____ cm

NEW Medical 110

Companion 75 90 110

Bariatric 120 Custom: _____ cm

✓ Tick if Accessories Are Required

Cot side L/H R/H

Cot side protector L/H R/H

Cot side brackets (to fit other cot sides) L/H R/H

Grip handle collapsible Over bed pole

Headboard (removable) Footboard (removable)

Flexible hand control wand Other (please specify): _____

✓ Tick if You Require a Mattress

Please view www.mortonperry.co.nz or our catalogue for specifications

Width cm: 75 85 90 110 120 135 150 Custom: _____ cm

Length cm: Standard 200 Custom: _____ cm

High Risk – Visco Memaflex Airlayer

Wheelchair User Thevoflex (110cm width only)

High Risk – Alternating Air New Elite Elite Comfort Delta

High Risk – Pain Management Vicair

Other Permaflex Innerspring Specify _____

Delivery Details

Date Required: _____

Delivery Address: _____

Contact Name: _____ Phone: _____

Special Instructions: _____