Equipment Used or Needed				
	Equipment	**Yes**	**No**	**Additional Information**
1.	Power Scooter			
2.	Manual Wheelchair			
3.	Power Wheelchair			
4.	Shower Chair-Bench			
5.	Brace			
6.	Artificial Body Part (specify below)			
7.				
8.	Crutches – Arm Braces			
9.	Cane			
10.	Walker			
11.	Lift Chair			
12.	Transfer Board			
13.	Hoyer Lift			
14.	Single Bed			
15.	Double Bed			
16.	Manual Hospital Bed			
17.	Automatic Hospital Bed			
18.	Hospital Bed (Other)			
19.	Bed Rails			
20.	Sleep Breathing Device (C PAP)			
21.	Therapeutic Mattress			
22.	Other (specify below)			
23.				
24.				
25.				
26.	I.V. Supplies			
27.	Special Utensils			

Equipment Used or Needed				
	Equipment	Yes	No	Additional Information
28.	Feeding Tube			
29.	Liquid Nutrition			
30.	Glasses			
31.	Contact Lenses			
32.	White Cane			
33.	Talking Clock			
34.	Magnifying Glass			
35.	Hearing Aid			
36.	TTY Device			
37.	Cell Phone			
38.	Communication Board			
39.	Calendar			
40.	Planner or Organizer			
41.	Programmable Watch			
42.	Blood Sugar Level Monitor			
43.	Syringes			
44.	Blood Sugar Test Strips			
45.	Lancets			
46.	Alcohol Swabs			
47.	Home Oxygen			
48.	Tracheotomy Ventilation System			
49.	Modifications for Allergies			
50.	Other (specify below)			
51.				
52.				
53.				