Equipment Request Worksheet

Bring this page to appointments, calls, or pickup. Clear details help programs match you with safe equipment faster.

Person who will use the equipment	
Phone / Email	
Address (City/State/ZIP)	
Primary contact if different (caregiver/advocate)	
Insurance (check all that apply)	[ ] Medicare [ ] Medicaid [ ] VA [ ] Private plan [ ] None
Equipment needed (be specific)	
When it's needed	[ ] ASAP [ ] Within 1 week [ ] Within 1 month [ ] Flexible
Measurements / fit (examples below)	
Mobility notes (if relevant)	Can transfer? [ ] Yes [ ] No Uses stairs? [ ] Yes [ ] No Falls risk? [ ] Yes [ ] No
Doctor / clinic name	
Prescription/DME order status	[ ] Requested [ ] Received [ ] Sent to supplier/program

Helpful measurement prompts

- Height: _____ Weight: _____
- Wheelchair: seat width _____ seat depth _____ weight capacity needed _____
- Walker/Rollator: handle height needed _____ brakes needed? [ ] Yes [ ] No
- Hospital bed: mattress size _____ rails? [ ] Yes [ ] No lift? [ ] Yes [ ] No
- Bathroom safety: shower type (tub/walk-in): _____ space constraints: _____