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| **HEALTH RELATED SUPPORTS AND PROTECTIVE EQUIPMENT AUTHORIZATION FORM**  *Supportive and Protective Devices may only be used in accordance with 115 CMR 5.12* | |
| **Name:** Click here to enter individual’s name. | **Date of Authorization:** Click or tap to enter a date. |
| **Type of Support/Equipment:**  Click or tap here to enter text. | |
| **Clinical Purpose and Justification:** (Describe the individual’s health or safety condition and the clinical rationale for the use of the support or equipment, including how it promotes safety, treatment, or functional engagement.  Click or tap here to enter text. | |
| **Frequency and Duration of Use:**  Click or tap here to enter text. | |
| **Specific Procedures for Proper Application:**  Click or tap here to enter text. | |
| **Instructions Routine Safety Checks** (Include what staff must check, inspected for damage how often, and where to document findings.:  Click or tap here to enter text. | |
| **Maintenance Requirements for Equipment** (E.g., how often device is cleaned, or adjusted for fit.):  Click or tap here to enter text. | |
| **Conditions Requiring Modification or Discontinuation:**  Click or tap here to enter text. | |
| **Health Related Support or Protective Equipment Authorization Type** *(Select based on the intended use of the support or equipment and complete required fields-* *If a valid medical order is present, a signature on this form is* ***not required****.)* | |
| **Health Related Support (***Used to promote proper body position and balance, enable safe participation in daily activities, prevent re-injury or infection, or support evacuation for individuals unable to evacuate independently.)*  **Name of Practitioner:**Click or tap here to enter text.  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** Click or tap to enter a date. | **Health Related Equipment for Self-Injurious Behavior (SIB)**  Authorized by PBS Qualified Clinician  Part of Intensive PBSP  **Name of Clinician:**Click or tap here to enter text.  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** Click or tap to enter a date.  **Human Rights Committee Review:**  **Name of HRC Member:** Click or tap here to enter text.  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** Click or tap to enter a date. |
| **Health Related Equipment for Medical Use**  **Ordered by:** Physician  Nurse Practitioner (NP)   Physician Assistant (PA)  Dentist  **Name of Practitioner:**Click or tap here to enter text.  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** Click or tap to enter a date. |

Revised July 2025. Use of this form is optional; it includes all DDS regulatory requirements for supports and equipment (CMR 5.12).