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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, Discontinuation, or Immediate Action:** 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)* | |
| **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. |