

Healthcare Professional Information:

Name:

Job Title (optional):

Facility/Organization (optional):

Phone:

Patient/Client Requesting: (check all that apply) Home Visit Information

(Set-up can be completed during a Home Visit)

Funding will be provided by: (3rd Party Payer)

 Veteran Affairs Canada ID#: _____ Other: _____ Urgent Install - Discharge Date: _____ Fall Detection RecommendedPatient Information:
(please print clearly)Name: Mr. Mrs. Ms.

Address:

City:

Province:

Postal Code:

Phone:

Best Time to Call:

 AM PM Check here if Patient/Client is primary contact**Additional Contact**

Name:

Phone:

Best Time to Call:

 AM PM

Relationship:

Additional Notes / Special Instructions:

Call us for low-income or
subsidy information

BEDFCARES - 99R

Please read and complete:

Consent and Privacy Notice: By submitting this form you acknowledge that you have obtained consent from the prospective subscriber named on this form to: 1) release their personal information to Bedford Medical Alert, 2) that the information will be used to contact the prospective subscriber for the purposes of further explaining Bedford's Products and Services (there is no obligation to accept any Products or Services), 3) the prospective subscriber also agrees that Bedford Medical alert can share the outcome regarding their decision to take/not take the Bedford Service with you.

Signature: _____

For Bedford Office Use ONLY

Organization Code:

Reference #:

Personnel ID #:

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