

Agency Survey Addendum: **Medical Equipment & Supplies**

Agency Name: _____

This form is used for clinics, hospitals, and other health care providers. Please complete this form in addition to the agency, so we are able to get a clear picture of the services you provide and the populations you serve. Choose all that apply to your organization.

Medical Equipment

- Adapted healthcare advices
- AIDS/HIV/STD prevention kits
- Compression hosiery
- Eye patches
- First aid kits
- Hernia supports
- Incontinence supplies
- Insulin injection supplies
- Medical dressings

Respiratory Equipment

- Air purifiers
- Humidifiers
- Oxygen
- Oxygen system accessories
- Portable volume ventilators

Monitoring Equipment

- Apnea monitors
- Blood pressure monitors
- Heart monitors
- Home glucose monitoring systems
- Nebulizers
- Needle exchange programs
- Ostomy supplies
- Physical/occupational therapy aids

Sickroom Equipment/Supplies

- Toileting aids
- Cushioning/support devices
- Hospital beds
- Pressure reduction mattresses/beds

Other:

Signature

Date

Title