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