CPM RENTAL FORM 2020

Surgery Date: _____ Date Required: _____

Unit Required: _____

PATIENT INFORMATION

Full Name: _____

.

Address: _____

Contact Number: (H): _____ Cell #: _____

THERAPIST & DOCTOR INFORMATION

Referred By: _____

Telephone #: _____

Therapist (if applicable): _____

Telephone #: _____

Hospital (her surgery is taking/taken place): _____

WSIB INFORMATION (If applicable)

Claim #: _____

Requested Duration: (minimum rental period is 21 days): _____

Notes: (Please tell us of any other information that you would like to address)

_____
_____
_____
_____
_____

Once completed or for any questions regarding the CPM rental please contact Annina;
1-800-267-5822 ext.234 or e-mail at annina@remingtonmedical.com