OWCS / SCOO
OTTAWA WEST COMMUNITY SUPPORT
SERVICE COMMUNAUTAIRE D'OTTAWA-OUEST
Providing the assistance you need to stay at home

MEDICAL DRIVE REQUEST FORM

Date:		*Requested By:*	
☐ **New Client**	☐ **Ongoing Client**	☐ **One Time**	☐ **Out of Area**
☐ **Medical Transportation**	☐ **Uses Walker** ☐ **Uses Wheelchair** ☐ **Uses Cane**	☐ **Needs Accompaniment** ☐ **Accompanied by family member/friend** ☐ **Yard/Snow Work**	☐ **Other (*please list)***

First Name:	**Last Name:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms
Street Address:	Postal Code:	Apt #	Ring #
Phone:			

Details of Request: (please include date, time and destination)	*Office Use*
1.	
2.	
3.	
4.	

New Client Information (to be completed if client has not received OWCS services)	
Date of Birth: _____/______/______ DAY MONTH YEAR	*Health Concerns/Medical Aids/Other Notes*
Office Use:	

Updated October 2012