

**AADL Speciality Suppliers Breast Prosthesis Fitter's Form**

Client's Information		
Client's Name: (Last) (First)	Date of Birth	Personal Health Number (PHN)
Date of Fitting: Year/Month/Date		

Check off all that apply:

Is this a pre-scheduled appointment?	Yes	No
Is this an initial fitting or repeat?		
Fitting for: __Lt __Rt or __ bilateral		

**The following is for initial clients only:**

1) How many weeks post-op is the client? _____	Yes	No
2) Is there tenderness? If yes, do not proceed and refer the client back to her GP		
3) Is there swelling at the incision site? If yes, has the edema been: a) Investigated? If no, refer back to their physician b) Reduced or stabilized? If no, refer back to their physician		
4) Has AADL cost sharing been explained to the client?		
5) Have you offered the client choice of product at benchmark or below? If No, explain why?		
6) Have you suggested that the client adds their breast prosthesis to their homeowner's or renter's insurance?		

Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Vendor Name and number:
Fitter's Name:

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_