



Society For Manitobans With Disabilities

Wheelchair Services

1111 Winnipeg Avenue, Winnipeg, Manitoba R3E 0S3

Ph: (204) 975-3250 Fax: (204) 975-3240 Toll Free: 1-800-836-5551

Category 4 Ultra light Wheelchair Request Form – Rigid and Folding Frames

Request type: New [ ] Exchange [ ]

Date of application: \_\_\_\_\_

CLIENT INFORMATION

PHIN Gender M F Birth Date Year/ Month/ Day

Surname Given Name

Address City/Town Prov Postal Code

Home Phone # Height (cm) Weight: (kg) (in) (lbs)

Is applicant covered by any other funding sources: DVA : Yes [ ] EIA : Yes [ ] MPI: Yes [ ] WCB: Yes [ ] No to all [ ]
Treaty Status 10 digit Treaty # \_\_\_\_\_
If treaty status, must have: dr.'s name \_\_\_\_\_ (please print) signature \_\_\_\_\_ and registration # \_\_\_\_\_
If EIA, case # \_\_\_\_\_ case worker \_\_\_\_\_ phone# \_\_\_\_\_ fax \_\_\_\_\_

Primary Diagnosis

Functional Mobility Requirements

Delivery Instructions if address different from above.
If in hospital you must indicate discharge date. \_\_\_\_\_
Can client or family pick up wheelchair from 1111 Winnipeg Ave? yes [ ] contact person and phone number \_\_\_\_\_

NEXT OF KIN

Surname: Given Name: Relationship:

Address City/Town Prov Postal Code

Home Phone # Work Phone #:

SCRIPTER

Scripter's Name : Occupational Therapist [ ] Physiotherapist [ ]

Address City/Town Prov Postal Code

Phone # Fax #: e-mail address:

**WHEELCHAIR JUSTIFICATION**

Applicant is a full time wheelchair user: yes  no

Amount of daily use of wheelchair (hours): \_\_\_\_\_

Applicant frequently propels into the community alone: yes  no  How many times per week \_\_\_\_\_

List activities performed in community: \_\_\_\_\_

Does the user require:

- horizontal axel adjustment: yes  no  How much \_\_\_\_\_

If yes, why? \_\_\_\_\_

-vertical axle adjustment: yes  no  How much \_\_\_\_\_

If yes, why? \_\_\_\_\_

- foot rest position other than 70 degrees? yes  no  If yes, what position and why? \_\_\_\_\_

-rigid frame: yes  no  If yes, why? \_\_\_\_\_

List the most important features that the chair must have to adequately address the client's needs: \_\_\_\_\_

Muscle grade strengths for the following: Shoulder abd'n: \_\_\_\_\_ add'n \_\_\_\_\_ flex'n \_\_\_\_\_ ext'n \_\_\_\_\_

Elbow flex'n \_\_\_\_\_ ext'n \_\_\_\_\_ Wrist flex'n \_\_\_\_\_ ext'n \_\_\_\_\_

**WHEELCHAIR DETAILS**

**Chair type requested:** folding  rigid  rigid with swing away front rigging

**Wheelchair seat width:** consider widest part of client, i.e. hips, thighs, knees, upper trunk/shoulder and add 1-2" as necessary for clearance on either side: client measurement at widest point \_\_\_\_\_

**w/c measurement:** \_\_\_\_\_

**Wheelchair seat depth:** measure posterior buttocks to popliteal fossa and subtract 1-2" as necessary. Consider leg length discrepancy and position of feet on foot plates: client measurement \_\_\_\_\_

**w/c measurement:** \_\_\_\_\_

**Lower leg length** – client measurement: \_\_\_\_\_ **wheelchair hanger length:** \_\_\_\_\_ (consider footwear, clearance under foot rests, height of compressed cushion)

**Front floor to seat height : w/c measurement** \_\_\_\_\_

**Rear floor to seat height: w/c measurement:** \_\_\_\_\_

**Wheelchair back height:** consider height of compressed cushion and/or if canes impede arm movement

Client measurement: \_\_\_\_\_ **w/c measurement** \_\_\_\_\_

**Size of seating components have been taken into consideration related to these measurements:** yes

**If rigid frame requested, it has been assessed that the front riggings do not interfere with transfers :** yes

**If rigid frame requested, it has been assessed that the wheelchair will fit into the applicant's vehicle:** yes

If request is approved, the referring therapist may be contacted and requested to complete an order form if necessary

**ENVIRONMENTAL ASSESSMENT**

A home visit is required in order to ensure to ensure that there are no restrictions to wheelchair use/wheelchair dimensions in applicant's home. Consideration should also be made to work, school and leisure environments.

A home visit was done by scripter: yes  no

Is the applicant able to safely and independently access their home via ramp, lift or level entrance? Yes  No

If no, describe plans to ensure accessibility: \_\_\_\_\_

Which of the following require modification in order to accommodate an ultra light weight wheelchair?

Doorways

Hallway turning radius

Bathroom

Bedroom

Kitchen

Flooring type

Describe plans to ensure accessibility:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comment on suitability of work, school and leisure environments:

If it is not possible to complete a home visit, discuss what has been done to ENSURE assessment/consideration of home environment as it relates to the wheelchair being requested, along with the reason the home visit could not be completed.

**Therapist Confirmation**

**The information in this application is based on a thorough assessment which includes but is not limited to a mat assessment, environmental assessment and a functional assessment of client's needs. It is my opinion that provision of an ultra light weight wheelchair is the minimum equipment required to improve this applicant's functional status.**

\_\_\_\_\_ (therapist's signature)

**EQUIPMENT LOAN AGREEMENT**

The equipment is the property of the Winnipeg Regional Health Authority (WRHA) and is loaned through the Manitoba Wheelchair Program, operated by the Society for Manitobans with Disabilities Inc.

I accept the loan of the equipment on the following terms:

I am only entitled to use the equipment while I am a full time resident of Manitoba.

I will only use the equipment for my personal mobility.

I will use and store the equipment carefully to avoid damage or loss.

I will not remove the permanent identification tag attached to the equipment.

I will follow the preventative maintenance program and make the equipment available for servicing. If the equipment is damaged, I will notify the Manitoba Wheelchair Program and follow its repair instructions. If the equipment is damaged because I did not use or store the equipment carefully, I may be required to pay the cost of repair.

If I move within Manitoba, I will report my new address and telephone number to the Manitoba Wheelchair Program no later than 30 days following my move. If I move outside Manitoba, I will return the equipment before I leave the Province.

If I enter a personal care home in Manitoba, I may continue to use the equipment only if I have been a client of the Manitoba Wheelchair Program for the 6 months before I enter the personal care home.

I will not sell, loan or allow any other person to use the equipment.

The WRHA will have no responsibility for equipment repairs outside of Manitoba.

The WRHA may re-assess my need for the equipment at any time.

I will promptly return the equipment to the Manitoba Wheelchair Program if I am no longer eligible under the Manitoba Wheelchair Program or if I no longer need the equipment or if I do not observe the terms of this agreement.

If the equipment is not returned, I will pay the cost to replace the equipment.

This agreement binds my estate.

**PRIVACY STATEMENT:** The personal Health information on this application is treated in compliance with the "Personal Information Protection and Electronic Documents Act". You will receive a brochure summarizing SMD Services' privacy policy with your wheelchair notification letter. Please review the policy summary when you receive it, as it is our commitment to your privacy. SMD promises to safeguard your personal information in a secure and reasonable fashion while providing you with the highest level of professional service.

If I am a minor, I agree this is a contract to supply a necessary wheelchair and is binding on me when I reach 18. If I am signing on behalf of a minor, both the minor and I are individually liable for these obligations.

I have read and understand the terms printed on this form. I am legally bound by the terms and I accept the loan of the equipment on these terms. **As the applicant, I have been actively involved in this assessment and agree to the information provided in this application.**

Signed by client: \_\_\_\_\_ Date: \_\_\_\_\_

Signed by representative/legal guardian : \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Witness Name: \_\_\_\_\_