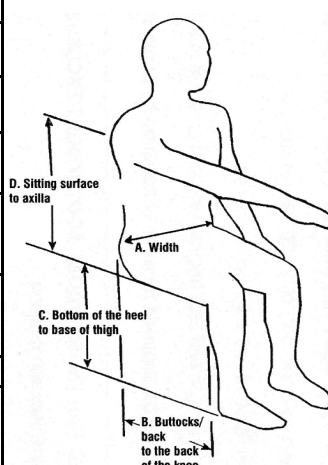


This application to be completed for all manual wheelchair requests (with the exception of category 4 ultra light weight)

Request Type: New  Exchange

<b>CLIENT INFORMATION</b>			<b>DATE OF APPLICATION</b>																																					
PHIN	Gender M <input type="checkbox"/> F <input type="checkbox"/>	DOB yy/mm/dd	Timeline (business days)	Winnipeg	Rural																																			
Surname	First Name		<input type="checkbox"/> <b>Regular</b>	4-12 days	5-12 days																																			
Address			<input type="checkbox"/> <b>Urgent *</b>	Within 3 days	Within 4 days																																			
City/Town	Postal Code		* those where the applicant is a full time user and/or has no other means of mobility within their home environment. Category 1 requests not included.																																					
Home#	Contact#		<input type="checkbox"/> <b>Other</b> (specify date required)		<b>Discharge Date</b>																																			
<b>MEDICAL INFORMATION</b>			<b>SCRIPTOR</b>																																					
Primary Diagnosis			Name:																																					
Secondary Diagnosis			Address:																																					
Degree of Impairment			City/Town:		Postal Code:																																			
Distance of independent ambulation (with/without aids) 0-25 m (80 feet) <input type="checkbox"/> 25-50 m (160 feet) <input type="checkbox"/>			Phone#		Fax#																																			
<b>NEXT OF KIN:</b>			<b>PHYSICIAN</b>																																					
Surname		First Name	Name:		Registration #																																			
Relationship		Address:		City/Town:																																				
Address:		City/Town:		Postal Code:																																				
City/Town		Phone#		Fax#																																				
Province		Postal Code		Signature:																																				
Home Phone #		Contact #		<b>BILLING INFORMATION</b>																																				
		DVA#		EIA#																																				
		WCB <input type="checkbox"/>		MPI <input type="checkbox"/>																																				
				Treaty #																																				
<b>METHOD/AMOUNT OF USE</b> (Check most appropriate box)			<b>APPLICANT'S MEASUREMENTS AND WHEELCHAIR SIZE</b>																																					
1. Self Propeller FT User <input type="checkbox"/> 2. Self Propeller PT User (4-8 hrs/day) <input type="checkbox"/> 3. Self Propeller Wkly Outings <input type="checkbox"/> 4. Attendant Assist FT User <input type="checkbox"/> 5. Attendant Assist PT User <input type="checkbox"/> 6. Attendant Assist Wkly Outings <input type="checkbox"/>			<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>CLIENT</th> <th>Height</th> <th>cm / in</th> <th>Weight</th> <th>kg/ lbs</th> </tr> </thead> <tbody> <tr> <td>Seat Width</td> <td><b>Measure A</b></td> <td>_____ + 1" to 2"</td> <td>=</td> <td></td> </tr> <tr> <td>Seat Depth</td> <td><b>Measure B</b></td> <td>_____ - 2"</td> <td>=</td> <td></td> </tr> <tr> <td>Seat Height</td> <td><b>Measure C</b></td> <td>_____ + 2" to 3" for footrest clearance, then minus compressed ht. of cushion</td> <td>=</td> <td></td> </tr> <tr> <td>Back Height</td> <td><b>Measure D</b></td> <td>_____ - 2" to 3" for arm propellers, then + compressed ht. of cushion</td> <td>=</td> <td></td> </tr> <tr> <td>Armrests</td> <td colspan="2">Full Length <input type="checkbox"/></td> <td colspan="2">Desk length <input type="checkbox"/></td> </tr> <tr> <td>Legrests</td> <td colspan="2">Standard: Right <input type="checkbox"/> Left <input type="checkbox"/> Elevating: Right <input type="checkbox"/> Left <input type="checkbox"/></td> <td colspan="2">Prescribed w/c will fit into clients home environment yes <input type="checkbox"/></td> </tr> </tbody> </table>			CLIENT	Height	cm / in	Weight	kg/ lbs	Seat Width	<b>Measure A</b>	_____ + 1" to 2"	=		Seat Depth	<b>Measure B</b>	_____ - 2"	=		Seat Height	<b>Measure C</b>	_____ + 2" to 3" for footrest clearance, then minus compressed ht. of cushion	=		Back Height	<b>Measure D</b>	_____ - 2" to 3" for arm propellers, then + compressed ht. of cushion	=		Armrests	Full Length <input type="checkbox"/>		Desk length <input type="checkbox"/>		Legrests	Standard: Right <input type="checkbox"/> Left <input type="checkbox"/> Elevating: Right <input type="checkbox"/> Left <input type="checkbox"/>		Prescribed w/c will fit into clients home environment yes <input type="checkbox"/>	
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<b>CATEGORY #</b> <b>1</b> <input type="checkbox"/> <b>2</b> <input type="checkbox"/> <b>3a</b> <input type="checkbox"/> <b>3b</b> <input type="checkbox"/> <b>4</b> <input type="checkbox"/> (Descriptors – other side)																																								
<b>ACCESSORIES:</b> Brake extension <input type="checkbox"/> Captive air tire <input type="checkbox"/> <b>Cushions – not available for category 1</b> (18 x 16 size only) Demedco <input type="checkbox"/> Firm foam <input type="checkbox"/>  <b>Not available on all models:</b> Headrest extension <input type="checkbox"/> One hand drive kit <input type="checkbox"/> Amputee axle kit <input type="checkbox"/>																																								
			<b>The information herein is based on current measurements and environmental factors</b> Scriptor Signature: _____																																					

**Equipment Loan Agreement:** I have read & understood the terms on the reverse side of this form. I am legally bound by the terms and accept the loan of the equipment on these terms.

Signed by Client \_\_\_\_\_ Witness Signature \_\_\_\_\_ Witness Name (Print) \_\_\_\_\_ Date \_\_\_\_\_  
 A representative may sign on behalf of a client. If you are signing as a representative, please complete information below.

Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_ Address/City/Town \_\_\_\_\_ Date \_\_\_\_\_

**GUIDELINES FOR WHEELCHAIR REQUESTS  
FROM THE EQUIPMENT POOL**

**GUIDELINES FOR EQUIPMENT REQUESTS**

1. Completed forms to be sent to Wheelchair Services
2. If forms are being sent by fax, only the front page needs to be sent.
3. Please note that Wheelchair Services maintains a recycled pool of equipment. Not all equipment will be new.
4. Prescribers are asked to request wheelchair according to the categories listed rather than by specific model. See Program Information Package – Appendix 1 for details

<b>CATEGORY</b>	<b>DESCRIPTION</b>
Category 1 : Standard Manual	SUITABLE FOR USERS WHO <ul style="list-style-type: none"> <li>• Require a wheelchair more than once per week, but less than 4 hours per day and can walk approximately 50 meters.</li> <li>• May or may not be able to self-propel</li> <li>• Require little or no adjustability</li> <li>• Require a back-up chair for motorized wheelchair.</li> <li>• Do not have a body weight in excess of 250 lbs. (113 kg).</li> <li>• Adult sizes available in 16, 18 , or 20 inch seat widths and 16 inch seat depth only. Pediatric sizes 14, 16 in. width &amp; 11, 13 in. depth.</li> <li>• Available in different seat heights</li> </ul>
Category 2 :  Lightweight  Standard Manual	<b>Provided to users who :</b> <ul style="list-style-type: none"> <li>• Must be self propellers who use the chair between 4 and 8 hours per day and can walk approx 25 meters.</li> <li>• If unable to walk, must use wheelchair &gt;8hrs/day</li> <li>• Various arm styles, rear wheel and caster sizes available</li> <li>• Available in 14, 16, 18 or 20 in. seat width &amp; 16-18 in. seat depth.</li> <li>• Wrap around and adjustable armrests</li> <li>• Various back and seat heights available on some models</li> <li>• <b>Will not be supplied for ease of handling by caregiver</b></li> </ul>
Category 3a and 3b:  Heavy Duty Standard Manual	REQUIRED FOR THOSE WHOSE BODY WEIGHT EXCEEDS 250 LBS <ul style="list-style-type: none"> <li>• Heavy duty construction, double cross braces on some models</li> <li>• Wrap around armrests</li> </ul> Available in 20 , 22 and 24 inch seat widths and 16-18 inch seat depth (depth is model dependent) <ul style="list-style-type: none"> <li>• 3a criteria as per category 1 usage, 3b criteria as per category 2</li> </ul>
Category 4 :  Specialty Chairs	<b>MUST BE PRESCRIBED BY A THERAPIST AND INCLUDE COMPLETION OF APPROPRIATE FORM/S AS DESCRIBED BELOW</b> <ul style="list-style-type: none"> <li>• <b>Reclining back</b> wheelchair -manual wheelchair request form and narrative note describing need for recline. <b>Client must be full or part time user.</b></li> <li>• <b>Manual tilt</b> in space wheelchair - manual wheelchair request form and the Letter of Support for Category 4 Manual Dynamic Tilt Form. <b>Client must be full or part time user.</b></li> <li>• <b>Ultra-light</b> wheelchair - Category 4 Ultralight Request Form. <b>Client must be an independent full time user, i.e. greater than 8 hours per day and cannot functionally ambulate.</b></li> </ul>

**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 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.
- 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.

PRIVACY STATEMENT

The personal Health information on this application is treated in compliance with the "Personal Information Protection and Electronic Documents Act". In order to serve you better we may need to share your personal information with others. Most commonly these include medical professionals. A summary of SMD Services privacy policy will be provided with your wheelchair notification. SMD promises to treat your personal information in a secure and reasonable fashion while providing you with the highest level of professional service.

