



**Society For Manitobans With Disabilities**

**Wheelchair Services**

1111 Winnipeg Avenue, Winnipeg, Manitoba R3E 0S3

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**Power Dynamic Positioning Device Exchange Application**

(to be used for all exchange requests for power dynamic positioning on power wheelchair bases)

Please Type or Print – Incomplete or Illegible Forms will be returned.

**SECTION A**

1. Name \_\_\_\_\_  
(Surname) (First Name)

2. Address: \_\_\_\_\_  
(Street or Box number) (City/Town)

Postal Code: \_\_\_\_\_ Telephone #: \_\_\_\_\_

3. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ MHSC #: \_\_\_\_\_ PHIN#: \_\_\_\_\_  
Year Month Day If box #, location of residence

4. Next of Kin or Contact Person: \_\_\_\_\_  
Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Telephone # \_\_\_\_\_

5. Name of Therapist: \_\_\_\_\_ Designation: \_\_\_\_\_

Agency and Address: \_\_\_\_\_

Telephone#: \_\_\_\_\_ E-mail address: \_\_\_\_\_

6. Date of exchange request: \_\_\_\_\_

7. Reason for exchange: \_\_\_\_\_  
\_\_\_\_\_

8. Is applicant covered by any of the following funding sources?

a. Employment and Income Assistance Yes  No

If yes, District Office \_\_\_\_\_ Fax # \_\_\_\_\_ File # \_\_\_\_\_

b. Medical Services Yes  No  If yes, Band Name \_\_\_\_\_

Treaty # \_\_\_\_\_ Physician's name (print) \_\_\_\_\_

and signature \_\_\_\_\_ Physician's 5 digit registration # \_\_\_\_\_

c. MPI Yes  No  WCB Yes  No  DVA Yes  No  A coverage  B coverage

DVA Worker \_\_\_\_\_ Phone # \_\_\_\_\_

**SECTION B: MEDICAL STATUS**

Diagnosis: \_\_\_\_\_ Has there been a change in Medical Status since the initial power dynamic positioning device application was submitted? Yes  No

If so, please describe (please comment on skin condition, respiratory status, etc) \_\_\_\_\_

Is the current dynamic positioning system positively influencing any of the following? :

- |                  |                          |               |                          |           |                          |
|------------------|--------------------------|---------------|--------------------------|-----------|--------------------------|
| Skin integrity   | <input type="checkbox"/> | Comfort       | <input type="checkbox"/> | Pain      | <input type="checkbox"/> |
| Bladder function | <input type="checkbox"/> | Hand control  | <input type="checkbox"/> | Tone      | <input type="checkbox"/> |
| Bowel function   | <input type="checkbox"/> | Head control  | <input type="checkbox"/> | Mobility  | <input type="checkbox"/> |
| Swallowing       | <input type="checkbox"/> | Vision        | <input type="checkbox"/> | Fatigue   | <input type="checkbox"/> |
| Respiration      | <input type="checkbox"/> | Communication | <input type="checkbox"/> | L/E edema | <input type="checkbox"/> |
| Digestion        | <input type="checkbox"/> | U/E mobility  | <input type="checkbox"/> |           |                          |

Please comment: \_\_\_\_\_

**SECTION C: LIFESTYLE / USAGE PROFILE**

1. The applicant uses the power wheelchair:  
Mostly in the community  Mostly inside home/suite  Inside home/suite & community
2. The current power wheelchair is used:  
As the primary method of mobility  Daily basis  2-3 times per week  Weekly

Comments: \_\_\_\_\_

**3. Usage Profile**

The applicant **REQUIRES** power Tilt/recline for the following activities: Describe why/how and include frequency of these activities

- |                   |                          |       |
|-------------------|--------------------------|-------|
| Feeding           | <input type="checkbox"/> | _____ |
| Dressing          | <input type="checkbox"/> | _____ |
| Grooming          | <input type="checkbox"/> | _____ |
| Toileting         | <input type="checkbox"/> | _____ |
| Bathing           | <input type="checkbox"/> | _____ |
| Meal Preparation  | <input type="checkbox"/> | _____ |
| Grocery Shopping  | <input type="checkbox"/> | _____ |
| Managing Finances | <input type="checkbox"/> | _____ |
| Light Cleaning    | <input type="checkbox"/> | _____ |
| Heavy Cleaning    | <input type="checkbox"/> | _____ |
| Laundry           | <input type="checkbox"/> | _____ |

4. Other activities applicant is currently involved in or would participate in, which require the use of power tilt/recline for independent involvement- be specific and include frequency:

\_\_\_\_\_  
\_\_\_\_\_

5. If the applicant requires the power tilt/recline for child care responsibilities, describe: or N/A

6. Is the applicant currently employed? Yes  No

Position held: \_\_\_\_\_  
Full time  Part time  Hours per day or week \_\_\_\_\_ day/ week (circle one)

How does a power tilt/recline feature facilitate employment? \_\_\_\_\_

7. Is the applicant presently enrolled in an education program? Yes  No

Institution applicant attending: \_\_\_\_\_

Program: \_\_\_\_\_

Full time  Part time  Hours per day or week: \_\_\_\_\_ day/week (circle one)

How does power tilt/recline participation in education program? \_\_\_\_\_

8. Is the applicant presently involved in volunteer activity? Yes  No

Organization: \_\_\_\_\_

Full time  Part time  Include the number of hours per day or week \_\_\_\_\_ day/week (circle one)

How does power tilt/recline facilitate participation in volunteer activities? \_\_\_\_\_

9. If this applicant has regularly scheduled medical appointments please qualify by describing the frequency of these appointments and the time spent at the appointments. Does power tilt/recline facilitate these appointments? Describe N/A

10. Does the applicant participate in recreational activities/socialization? Yes  No

(This would include participation in activities that client does in home and community with family/friends)

1. Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_

2. Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_

3. Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_

4. Day Program \_\_\_\_\_ Frequency \_\_\_\_\_

How would a power tilt/recline affect/facilitate participation in these activities? \_\_\_\_\_

11. Approximate the total number of hours/day engaged in the above power mobility (#1-10) related activities:

**SECTION D: SUPPORT SYSTEMS**

Describe the effect (if any) that the power wheelchair/power tilt/recline has had on the applicant's support system:

\_\_\_\_\_  
\_\_\_\_\_

**SECTION E: PHYSICAL ENVIRONMENT**

1.a) Indicate setting of client's home: Rural  Urban

b) Indicate the presence of the following (Check all that apply):

Paved streets  Paved sidewalks  Gravel roads  Gravel sidewalks  No sidewalks  Curb cuts

2. a) Describe client's living environment:

Private home: owned  rented  Group Home:  Long Term Care Facility:   
Apartment/Condo: owned  rented  Other:  \_\_\_\_\_

b) Home Accessibility:

Entrance has a lift  or ramp  or level entrance  Lift/ramp has safe railing

Doorway widths: Main entrance: \_\_\_\_\_ Bathroom: \_\_\_\_\_ Bedroom: \_\_\_\_\_  
Kitchen: \_\_\_\_\_ Living Room: \_\_\_\_\_ Other: \_\_\_\_\_

Power Chair can maneuver through/in: Bedroom  Bathroom  Kitchen  Living Room   
Hallways  Other  \_\_\_\_\_

Will/Do any of the following cause difficulties or safety problems:

Carpets  Tight corners  Elevators  Stairs  Bathroom size   
Narrow halls  Open stairs  others  \_\_\_\_\_

Who did a home visit to verify this information? \_\_\_\_\_

If residence is not fully accessible, describe plans for making it so: \_\_\_\_\_

3. Does the applicant have a safe (locked) and suitable (dry and warm) location in which to store the power wheelchair?

Yes  No  Where: \_\_\_\_\_

4. Is battery maintenance being performed? Yes  No

5. Is the individual able to transport the power wheelchair? Yes  No  describe: \_\_\_\_\_

**SECTION F: POWER WHEELCHAIR ASSESSMENT**

1. During assessment in power wheelchair, can the applicant do the following?

	Yes	No
Move wheelchair in at least one direction.	<input type="checkbox"/>	<input type="checkbox"/>
Move wheelchair forward.	<input type="checkbox"/>	<input type="checkbox"/>
Stop within 5 seconds on request.	<input type="checkbox"/>	<input type="checkbox"/>
Move toward an object and stop appropriately before hitting object.	<input type="checkbox"/>	<input type="checkbox"/>
Keep head up and attend to surroundings.	<input type="checkbox"/>	<input type="checkbox"/>
Drive around obstacles	<input type="checkbox"/>	<input type="checkbox"/>
Drive through doorways	<input type="checkbox"/>	<input type="checkbox"/>
Travel along a narrow hallway	<input type="checkbox"/>	<input type="checkbox"/>
Turn around inside a small room and exit the room	<input type="checkbox"/>	<input type="checkbox"/>
Reverse safely	<input type="checkbox"/>	<input type="checkbox"/>

Does the applicant	Yes	No
Have cognitive skills for safety?	<input type="checkbox"/>	<input type="checkbox"/>
Have perceptual skills for safety?	<input type="checkbox"/>	<input type="checkbox"/>
Have adequate vision skills to be safe and independent?	<input type="checkbox"/>	<input type="checkbox"/>
Pay visual attention to environment?	<input type="checkbox"/>	<input type="checkbox"/>
Have adequate hearing skills to be safe and independent?	<input type="checkbox"/>	<input type="checkbox"/>
Display speed control in driving?	<input type="checkbox"/>	<input type="checkbox"/>
Display directional control in driving?	<input type="checkbox"/>	<input type="checkbox"/>
Have the ability to focus on one activity for 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>
Have the ability to drive in a structured environment?	<input type="checkbox"/>	<input type="checkbox"/>
Have the ability to drive in an unstructured environment?	<input type="checkbox"/>	<input type="checkbox"/>

2. **Can the applicant use power mobility independently?** Yes  No  If no, describe what supports are /supervision is needed.

\_\_\_\_\_

3. **For exchange requests, when an alternative drive controls is being requested, is it likely that extensive training will be needed in order for client to safely use a power wheelchair?**  
 Yes  No

If yes, estimated time training would be required: \_\_\_\_\_

If yes, where would training occur? \_\_\_\_\_

Training/Follow-up plans: \_\_\_\_\_

### SECTION G: SEATING ASSESSMENT

Describe positioning in current wheelchair

Head/Neck: \_\_\_\_\_

Shoulders: \_\_\_\_\_

Trunk: \_\_\_\_\_

Pelvis: \_\_\_\_\_

Hips: \_\_\_\_\_

Knees: \_\_\_\_\_

Feet: \_\_\_\_\_

**Seating has been reassessed and current seating components are suitable for new power chair.** Yes

**If not, what changes are required?** \_\_\_\_\_

\_\_\_\_\_

### SECTION H: THERAPIST'S IMPRESSIONS

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 continued provision of power wheelchair with power dynamic positioning is the minimum equipment required to improve this applicant's functional status.

Therapist's Signature: \_\_\_\_\_

## SECTION I: WHEELCHAIR SPECIFICS

**Note: If midwheel drive power wheelchair is being requested, complete Mid Wheel Drive – Addendum to Power Wheelchair Application in lieu of this page.**

Power Positioning Assessment Specifications:

Wheelchair dimensions: *Please record the measurements for the wheelchair, not the client's body measurements, in the spaces below.*

Power Positioning: Power tilt  Power recline  Power tilt and recline  Power elevating leg rests

Seat width \_\_\_\_\_ inches Seat depth \_\_\_\_\_ inches Back height \_\_\_\_\_ inches

Floor-to- Seat height \_\_\_\_\_ inches If available: Seat angle \_\_\_\_\_ Seat/back angle \_\_\_\_\_

### Wheelchair options:

Headrest: Yes  No  Seatbelt: Yes  No  Omit back upholstery: Yes  No

Armrests: Full length  Desk length

Leg rests: Standard: Right  Left  N/A  Elevating: Right  Left  N/A

Control: Right  Left  Hand Joystick controls Other  \_\_\_\_\_

Will it be necessary to fit or mount to the chair other devices related to any of the following? (Check all that apply).

Communication  Environmental   
Ventilator  Seating  None required

If yes, describe equipment needed \_\_\_\_\_

Is delivery to home address? Yes  No  deliver to: \_\_\_\_\_  
(Note: Wheelchair Services will deliver to ONE address only.)

**Battery information:** The WRHA Manitoba Wheelchair Program provides sealed (gel cell) batteries for power wheelchair users. These batteries require regular charging to ensure functional use and this is the responsibility of the consumer.

Who will perform battery maintenance? \_\_\_\_\_