



Society For Manitobans With Disabilities
 Wheelchair Services
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Winnipeg Regional Health Authority
 Office régional de la santé de Winnipeg

POWER DYNAMIC POSITIONING DEVICE REQUEST FORM
 Part 1, Section A

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

1. Name _____
 (Surname) (First Name)

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

Postal Code: _____ Telephone #: _____

If box #, location of residence: _____

3. Date of Birth: ____/____/____
 Year Month Day

4. PHIN Number: _____ MHSC Number: _____

5. Next of Kin or Contact Person: _____

Relationship: _____ Telephone #: _____

Mailing Address: _____
 (Street or Box number) (City/Town)

Postal Code: _____

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

• Employment and Income Assistance Yes No

District Office _____ Fax # _____ File # _____

• Medical Services Yes No

Band Name _____ Treaty # _____

Physician's name (print) _____ Physician's signature _____

Physician's registration # _____

• MPI Yes No

• WCB Yes No

• DVA Yes No A coverage B coverage

DVA Worker _____ Phone # _____

• Other: _____

SCRIPTER INFORMATION

Scripter's Name: _____ (Please print).

Designation: _____ Agency: _____

Address: _____ e-mail address: _____

Postal Code: _____ Telephone: _____ Fax: _____

Signature: _____ Date: _____

Section B: MEDICAL INFORMATION

1. Primary diagnosis: _____

Date of onset: _____

Is condition progressive? Yes No

Prognosis: _____

Secondary diagnosis: _____

2. Relevant Medical History: (eg. cardiac problems, respiratory status)

3. Applicant's weight _____ lbs/kgs (circle one) Applicant's height _____ inches/cm (circle one)

4. Skin Condition:

a) Describe current skin integrity: Intact Reddened areas Open areas

Describe? _____

b) Does applicant have a history of skin breakdown? Yes No

Where? _____

Past surgeries give details _____

Scar tissue location: _____

c) Describe skin management program (eg bed rest, limited sitting times etc): _____

d) Sensation: Normal Impaired describe _____

SECTION C: CURRENT MOBILITY

If client has either a manual or motorized wheelchair, please complete the following section.

1. MANUAL WHEELCHAIR: Make and Model: _____
Date obtained: _____ From Whom: _____
Wheelchair Seat: Width: _____ Depth: _____ Back Height: _____ Seat Height: _____
Functional Use: _____
Seating: Seat: _____
Back: _____
Accessories: _____
Other: _____
2. MOTORIZED WHEELCHAIR: Make and Model: _____
Date obtained: _____ From Whom: _____
Wheelchair Seat: Width: _____ Depth: _____ Back Height: _____ Seat Height: _____
Functional Use: _____
Seating: Seat: _____
Back: _____
Accessories: _____
3. Which is the primary system? Manual Motorized
4. In the primary system have the following been assessed?
 - a) Lateral supports no yes
 - b) Back rests no yes list types assessed _____
 - c) Cushions no yes list types assessed _____
 - d) Changes to the seat to back angle no yes what angle/s? _____
 - e) Changes to the seat angle no yes what angle/s? _____Other: _____
Briefly describe the successes and limitations of equipment assessed: _____

A MAT ASSESSMENT MUST BE COMPLETED. IF THIS HAS ALREADY BEEN DONE PLEASE ATTACH ALL DOCUMENTATION

SECTION D: SEATING ASSESSMENT

1. Describe positioning in current wheelchair

Head/Neck: _____

Shoulders: _____

Trunk: _____

Pelvis: _____

Hips: _____

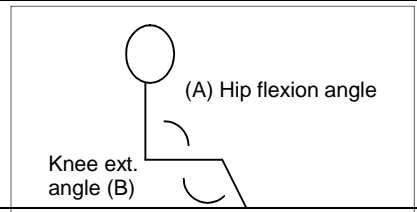
Knees: _____

Feet: _____

POSTURE IN SUPINE (on solid surface eg. plinthe)

Pelvis:

Tilt: **Neutral** Posterior tilt Anterior Tilt
 Flexible Fixed Flexible Fixed
 Rotation: **Neutral** Rotated forward left right
 Flexible Fixed
 Obliquity: **Neutral** ASIS high left right
 Flexible Fixed



Hips: Range of Motion in degrees. (Use above diagram)

A) Flexion: **To full flexion** When flexing hips, measure range prior to shift into posterior pelvic tilt
 Left _____ Right _____ (angle A)
 B) Abduction: **To Neutral** If not to neutral, describe _____
 C) Adduction: **To Neutral** If not to neutral, describe _____
 D) Internal Rot: **To Neutral** If not to neutral, describe _____
 E) External Rot: **To Neutral** If not to neutral, describe _____

Knees: (with hip flexion as tolerated in A) – above)

F) Extension: **To full extension** When extending hips, measure range prior to shift into posterior pelvic tilt
 Left _____ Right _____ (angle B)
 G) Flexion: **To full flexion** If not full flexion, describe the range limitation _____

Leg length:

Leg length discrepancy? **No** Yes **Include measurements of both limbs**

Feet/Ankle: Neutral Lacks dorsiflexion Lacks plantarflexion Lacks inversion Lacks eversion

Other foot/ankle issue (describe) Right _____
 Left _____

Trunk:

Kyphosis: **Neutral** Present Curve: Thoracic Cervical Flexible Fixed
 Lordosis: **Neutral** Present Flexible Fixed
 Scoliosis: **Neutral** Present apex to left to right Flexible Fixed
 Rotation: **Neutral** Shoulder rotated forward: left right Flexible Fixed
 Rib hump: **Neutral** Present Describe _____

Shoulders:

Appear level

Elevated: left right Flexible Fixed Depressed: left right Flexible Fixed
 Retracted: left right Flexible Fixed Protracted: left right Flexible Fixed

Head/Neck:

Flex/Ext: **Neutral** Flexed Extended Flexible Fixed
 Lateral Flex.: **Neutral** ear down to left right Flexible Fixed
 Rotation: **Neutral** nose to left right Flexible Fixed
 Chin poke: **Neutral** Present Flexible Fixed

POSTURE IN SITTING (on solid surface eg. plinthe)

Short sit on flat surface – place client in seated position based on range limitations noted on the supine mat evaluation.

Sitting Balance: **Hands free, can shift out of midline** Hands free, no weight shift
Uses own hands on surface to stay upright Requires assistance

Assistance required: **None** Minimum Moderate Maximum

Comments and unsupported position: _____

Pelvis: If found flexible in supine, use your hands or wedges to support the pelvis in a neutral position.
If found fixed in supine, accommodate by using your hands or wedges to support the pelvis in neutral position.

1. Describe where the **supports** are provided to position the pelvis in the most neutral position (eg. PSIS, lumbar support, etc.)

2. Describe **position** of the pelvis for seating system.

Tilt: **Neutral** Posterior tilt Anterior Tilt

Rotation: **Neutral** Rotated forward left right Support to be placed behind left right

Obliquity: **Neutral** ASIS high left right Support to be placed under left right

Hips: Position to angle (angle A) determined in supine.

Comments: _____

Knees: Position to angle (angle B) determined in supine.

Comments: _____

Feet/Ankle: Place in position determined in supine. Write position here _____

Comments: _____

Trunk: Support the pelvis, hips, knees and ankles in positions described, above.

1. Assess for scoliosis

Scoliosis: **Neutral** Present Flexible Fixed
Apex at: lumbar thoracic cervical

2. If trunk found **flexible in supine**, support trunk in neutral.

Describe where the supports are needed:

If trunk found **fixed in supine**, support fixed postures and determine best trunk position for optimal function, balance, eye gaze, etc.

Describe where the supports are needed: _____

3. Describe the trunk position for the seating system with check boxes, below.

Kyphosis: **Neutral** Present lumbar thoracic cervical

Lordosis: **Neutral** Present lumbar thoracic cervical

Scoliosis: **Neutral** Present Flexible Fixed

Apex at: lumbar thoracic cervical

Rotation: **Neutral** Pelvis or Trunk rotated forward left right

Rib hump: **Neutral** Present Describe _____

Draw scoliosis here
(label left and right)

Shoulders: Support the trunk, pelvis, hips, knees and ankles in positions described, above.

Describe position of the shoulders for the seating system with check boxes, below.

Level

Elevated: left right Depressed: left right Retracted: left right Protracted: left right

Head/Neck: Support the shoulders, trunk, pelvis, hips, knees and ankles in positions described, above.

Describe position of the head and neck for the seating system with check boxes, below.

Flex/Ext: **Neutral** Flexed Extended

Lateral Flex.: **Neutral** ear down to left right

Rotation: **Neutral** nose to left right

Chin poke: **Neutral** Present

Upper extremity: Support the head, shoulders, trunk, pelvis, hips, knees and ankles in positions described, above.

1. Describe any limitations in upper extremity function (strength, range of motion, tone, etc):

2. Describe the position of the upper extremity for the seating system. **WNL**

Other, describe: _____

Lower extremity: Support the trunk, pelvis, hips, knees and ankles in positions described, above.

Use of lower extremities: **WNL** None Partial describe _____

SECTION E: FUNCTIONAL STATUS

1. Repositioning:

a) Describe repositioning for the purpose of pressure reduction / redistribution:

Independent Assisted Dependent

b) How often is repositioning required? _____

c) How often is repositioning performed? _____

d) How often are caregivers available for repositioning client? _____

e) Are transfers an issue for client/caregiver? (eg. Is it difficult to position client in chair after a hooyer transfer)

2. Sitting Tolerance:

a) Total number of hours in the day spent in the wheelchair _____

b) Total number of pain free hours spent in the wheelchair _____

c) Number of hours that the client would like to be up in the wheelchair for _____

Comments: _____

3. Is positioning affecting the following: (Check all that apply and comment if necessary).

Skin integrity _____

Bladder function _____

Bowel function _____

Feeding/Swallowing _____

Respiration _____

Digestion _____

Hand Control _____

Head Control _____

Vision Communication _____

Tone _____

Mobility _____

L/E edema _____

Comfort _____

U/E Mobility _____

Pain _____

Fatigue _____

Other: _____

4. If elevating leg rests are required (standard or power) describe the factors that indicate their need: _____

SECTION F: ASSESSMENT INFORMATION

THE FOLLOWING GOALS MUST BE ARRANGED IN A SMART FORMAT. ie the goals must be:

- S = Specific Ask yourself the questions, "who, what, when, where and how?"
- M = Measurable Ask yourself the question, "How can I measure this complaint or issue?"
- A = Attainable (realistic) Ask yourself the question, "Are the client's goals too difficult to be met, considering their physical, cognitive, social and environmental barriers?"
- R = Relevant Ask yourself the question, "Is this goal meaningful to the client?"
- T = Time Related Ask yourself the question, "What kind of time frame should be used?"

1. Projected Goals of Power Positioning System:

1. _____

2. _____

3. _____

4. _____

2. Power Positioning Assessment Specifications:

Wheelchair dimensions: *Please record the measurements for the wheelchair, not the client's body measurements, in the spaces below. Applicant may not receive exact specifications for the two-week assessment.*

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 _____

DELIVERY INSTRUCTIONS: _____ PICK UP INSTRUCTIONS: _____

THIS SECTION TO BE COMPLETED BY SMD ONLY	
Assessment Equipment to be provided: _____	Serial # _____
Assessment Period _____	
Comments: _____	

DYNAMIC POSITIONING DEVICE ASSESSMENT FORM

Part 2

Client Name: _____ Phone: _____

Address: _____

Dynamic Positioning Device Being Assessed: _____

Date System Received: _____ Date of Assessment: _____

Therapist Name: _____ Phone: _____

SECTION G: ASSESSMENT RESULTS

1. Describe client's positioning in the new positioning system:

Head/Neck: _____

Shoulders: _____

Trunk: _____

Pelvis: _____

Hips: _____

Knees: _____

Feet: _____

2. What degree of tilt is required in order to support trunk in an upright position: _____
describe _____

3. What degree of tilt is needed in order to support head in an upright position? _____
describe: _____

4. Please list the objective outcomes of the trial of power elevating leg rests (if applicable)

5. Complete the "one-day profile" of the use of the dynamic positioning assessment system (see attached). It is recommended that this be done in the mid- to latter part of the assessment period.

"ONE DAY PROFILE"

RE: USE OF DYNAMIC POSITIONING SYSTEM

Client Name: _____ **Date:** _____

TIME	ACTIVITY	TIME UPRIGHT ____min (max 60)	TIME TILTED ____min (max 60)	TIME RECLINED ____min (max 60)	CLIENT NOT IN W/C ____min (max 60)
0000-0600 hrs					
0600-0700					
0700-0800					
0800-0900					
0900-1000					
1000-1100					
1100-1200					
1200-1300					
1300-1400					
1400-1500					
1500-1600					
1600-1700					
1700-1800					
1800-1900					
1900-2000					
2000-2100					
2100-2200					
2200-2300					
2300-2400					
TOTALS:		_____ MIN _____ HOURS	_____ MIN _____ HOURS	_____ MIN _____ HOURS	_____ MIN _____ HOURS

(round off to nearest 1/2 hour)

SECTION H: FUNCTIONAL STATUS

1. Repositioning:

- a) Describe repositioning for the purpose of pressure reduction:
Independent Assisted Dependent
- b) How often is repositioning required? _____
- c) How often is repositioning performed? _____
- d) How often are caregivers available for repositioning client? _____
- e) Has transfer status improved/changed with the use of the system? Describe _____
- f) Has the new system changed caregiver requirements? Please comment _____

2. Has the system increased sitting tolerance? Yes No

- a) Total number of hours in the day spent in the wheelchair _____
- b) Total number of pain free hours spent in the wheelchair _____

3. Has the system positively affected the following?: (Check all that apply and comment if necessary).

- Skin integrity _____
- Bladder function _____
- Bowel function _____
- Feeding/Swallowing _____
- Respiration _____
- Digestion _____
- Hand Control _____
- Head Control _____
- Vision Communication _____
- Tone _____
- Mobility _____
- L/E edema _____
- Comfort _____
- U/E Mobility _____
- Pain _____
- Fatigue _____

Other: _____

4. If skin integrity is an issue for this client please comment on how/if the system has affected skin. Include subjective and objective (eg FSA, skin checks etc) information. _____

5. If elevating leg rests (standard or power) were requested describe the objective outcomes of their trial: _____

6. Indicate whether the positioning system has resulted in improved function:

- ADL's
- IADL's
- Transfers
- School / Work
- Leisure / Recreation

7. Environment

Is the system compatible with the client's environment in the following areas?

- | | Yes | No |
|-----------------------------|--------------------------|--------------------------|
| a) Elevator access | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Work station heights | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Overall length of system | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Mode of transportation | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

SECTION I: THERAPIST RECOMMENDATIONS

1. Please refer to the projected goals listed in Part 1-Section E. Indicate whether the goals were achieved:

Goal #	Goal Achieved		Comments
	Yes	No	

2. Describe any additional benefits not originally anticipated when Part 1 of the assessment was completed.

Benefit	Comments

3. Comment on the limitations of the positioning system used for the assessment period:

4. Scriptor's general impressions on the suitability of the assessed power-positioning device: _____

5. Power Positioning Device Specifications:

Please indicate the final dimensions required. This information will be used to order the equipment for the client. Please ensure it is accurate.

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:

Armrests: Full length Desk length

Omit back upholstery: yes no

Leg rests: Standard: Right Left N/A

Control: Right Left hand joystick

Elevating: Right Left N/A

Other _____

Headrest: Yes No

(specify)

Seatbelt: Yes No

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

Communication

Seating

Environmental

Ventilator

None required

If yes, describe equipment needed _____

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? _____

DELIVERY INSTRUCTIONS: _____

THIS SECTION TO BE COMPLETED BY SMD ONLY

Results: Approved Denied for provision of power positioning device

Assessment equipment (Serial# _____): Assigned permanently to applicant

Returned to stock as of ___ / ___ / ___