Society For Manitobans With Disabilities

Wheelchair Services

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Power Wheelchair Follow-up ☐ **Power Wheelchair Exchange** ☐

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 #:** __________________ ___________________________________
   If box #, location of residence

3. **Date of Birth:** _____/_____/_____ **MHSC #:** _______________**PHIN#:** ______________________________________
   Year Month Day

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 follow-up / exchange request:** ___________________________________

7. **If exchange – 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 wheelchair application was submitted? Yes☐ No☐

If so, please describe: ____

If so, describe how this may relate to the individual's performance in the power wheelchair, or how it may change their need for a power wheelchair.

____

SECTION C: CURRENT MOBILITY

Comment in the applicant's ability to ambulate and/or use a manual wheelchair. Comment on level of independence and distances involved both indoors and out:

____

____

SECTION D: 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 <u>REQUIRES</u> power mobility for the following activities:		**Describe why/how and include <u>frequency</u> of these activities**
Feeding	☐	______________________________
Dressing	☐	______________________________
Grooming	☐	______________________________
Toileting	☐	______________________________
Bathing	☐	______________________________
Meal Preparation	☐	______________________________
Grocery Shopping	☐	______________________________
Managing Finances	☐	______________________________
Light Cleaning	☐	______________________________
Heavy Cleaning	☐	______________________________
Laundry	☐	______________________________

4. Other activities applicant is currently involved in or would participate in, which require the use of power mobility for independent involvement– be <u>specific</u> and include frequency:

____

____

5. If the applicant requires the power chair 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 chair 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 a power chair facilitate 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 a power chair 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 a power wheelchair facilitate/be used at 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 chair 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 E: SUPPORT SYSTEMS

1. **Describe the effect (if any) that the power wheelchair has had on the applicant's support system/caregiver requirements:**

____

____

SECTION F: 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 G: POWER WHEELCHAIR ASSESSMENT

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

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

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

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 H: THERAPIST'S IMPRESSIONS

Following the assessment of this individual, please comment on suitability of provision/continued provision of the power wheelchair to individual on a permanent basis.

____

____

____

____

____

____

Therapist's Signature: ____

SECTION I: WHEELCHAIR SPECIFICS
(TO BE COMPLETED ONLY FOR EXCHANGE REQUESTS)

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

1. **Applicant Information:** weight ________ lbs/kgs (circle one) height _________ inches/cm (circle one)

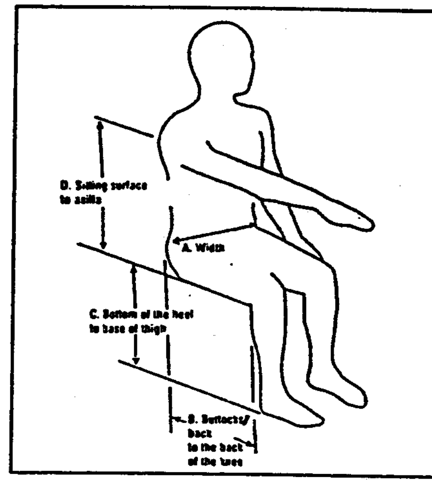
2. **Wheelchair dimensions:** Please consider client size, seating inserts, and functional usage of wheelchair when determining the wheelchair prescription. For example, the transfer method, wheelchair cushion, and applicant's height may all affect the recommended floor-to-seat height of the prescribed wheelchair.

Seat Width = Measure "A" _____+(1" to 2") = ☐

Seat Depth = Measure "B" _____ - (2") = ☐

Seat Height = Measure "C" ______
+(2" to 3" for foot pedal clearance)
– (compressed height of cushion) = ☐

Back Height = Measure "D" _______
-(2 to 3 if has good sitting balance) +(compressed height of cushion) = ☐



If available: **Seat angle** ____________
Seat/back angle __________

3. **Wheelchair options:**

Armrests Full length ☐ Desk length ☐

Leg rests Standard Right ☐ Left ☐
Elevating Right ☐ Left ☐

Control: Joystick: Right ☐ Left ☐
Other: Please specify: ___________________________________

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

Communication	☐	Positioning	☐	Environmental	☐
Respiratory	☐	Seating	☐	None required	☐

If yes, describe equipment needed (include information regarding intended supplier):

____

5. **Is it likely that specialty controls will be needed?** Yes ☐ No ☐

If yes, please describe ____

6. **Is delivery to home address?** Yes ☐ No ☐ deliver to: ____
(Note: Wheelchair Services will deliver to ONE address only.)

6. **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? ____