



**ELIGIBILITY CRITERIA – THERAPIST CONFIRMS THE FOLLOWING CONDITIONS APPLY**

- Applicant is a full time user (6+ hours per day)
  - Non ambulatory
  - Applicant has caregiver support to apply tilt at regular intervals throughout the day.
  - Assessments and equipment trials completed to date support the application of tilt as basic and essential for the applicant
  - Assessment results reveal the application of tilt is required for the following reasons: *(check all that apply and elaborate below)*
    - Pressure Management** (e.g. pressure redistribution, wound management)
    - Postural Support** (e.g. eye gaze, trunk extension, stability in chair)
    - Functional Optimization** (e.g. improve sitting tolerance, improve posture for feeding/swallowing)
    - Respiratory Function** (e.g. improve ease of suctioning or vent care, improve breathing/ air exchange)
    - Other** *(justification included below)* \_\_\_\_\_
  - Applicant has been informed the prescribed wheelchair will not collapse for transport
  - Applicant has been informed that SMD Wheelchair Services will not supply a backrest or cushion for the prescribed chair.
  - Home has an accessible entrance: *(circle one)* street level entrance    ramp    platform lift
- Verified by: \_\_\_\_\_

**PRESCRIPTION**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Ped: Zippie Iris | <input type="checkbox"/> 3A: Quickie SR45 (265 lbs.) | <input type="checkbox"/> 3A: Quickie Iris (300lbs) | <input type="checkbox"/> 3A: Quickie IrisHD (400lbs) |
|---|--|--|--|

**ORDER FORM FOR SELECTED TILT IN SPACE WHEELCHAIR ATTACHED**

**RATIONALE FOR WHEELCHAIR SELECTION: (MUST BE COMPLETED)**

**PRESSURE MANAGEMENT AND SKIN INTEGRITY EVALUATION**

**CURRENT SKIN INTEGRITY**

- INTACT**             **HISTORY OF BREAKDOWN**             **PRESSURE INJURY**  
 Describe:

**CURRENT PRESSURE MANAGEMENT STRATEGIES**

**CAN THE APPLICANT EFFECTIVELY REPOSITION FOR THE PURPOSE OF PRESSURE MANAGEMENT (I.E. OFFLOADING)?**  
 Describe:

**IF APPLICANT IS UNABLE TO EFFECTIVELY REPOSITION FOR THE PURPOSE OF PRESSURE MANAGEMENT, WHAT ALTERNATE STRATEGIES HAS THE APPLICANT/CAREGIVER INCORPORATED TO ADDRESS PRESSURE MANAGEMENT CONCERNS?**

**DOES THE APPLICANT AND/OR THEIR CAREGIVERS PERFORM REGULAR SKIN CHECKS?**  
 Describe:

**POSTURAL EVALUATION**

**DESCRIBE APPLICANT'S CURRENT SEATING SYSTEM AND RESTING POSTURE** (include wheelchair frame style, seating components and include description of any notable asymmetries at the hips, knees, trunk, head/neck)

**DESCRIBE RANGE OF MOTION LIMITATIONS AND/OR MUSCLE TONE CURRENTLY AFFECTING APPLICANT'S POSTURE IN SITTING:**

HIP ROM R: _____ L: _____	KNEE ROM R: _____ L: _____	ANKLE ROM R: _____ L: _____
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**DESCRIBE HOW THE USE OF TILT WILL IMPROVE APPLICANT'S POSTURE IN SITTING AND/OR WHY STATIC SEATING ALONE DOES NOT ADEQUATELY ADDRESS THE POSTURAL CONCERNS OUTLINED ABOVE:**

**FUNCTIONAL STATUS**

<b>TRANSFER STATUS</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> With Assistance	<input type="checkbox"/> Mechanical Lift
<b>PROPULSION STATUS</b>	<input type="checkbox"/> Independent	<input type="checkbox"/> Partially Independent	<input type="checkbox"/> Attendant Assist
<b>PROPULSION METHOD</b>	<input type="checkbox"/> Arms Only	<input type="checkbox"/> Feet Only	<input type="checkbox"/> Both
<b>SITTING TOLERANCE</b>	Total Sit time currently tolerated: _____		Desired Sit Time: _____

**DESCRIBE FACTORS THAT LIMIT APPLICANT'S SIT TIME:**

**DESCRIBE HOW THE USE OF TILT WILL ENHANCE APPLICANT'S FUNCTION**

**RESPIRATORY STATUS**

**DESCRIBE HOW THE USE OF TILT WILL IMPROVE APPLICANT'S AIR EXCHANGE/ RESPIRATORY STATUS:**  
 (Include Objective Data if available)

**APPLICANT MEASUREMENTS – INFORMATION PROVIDED MUST REFLECT CURRENT MEASUREMENTS**

<b>CURRENT WEIGHT:</b> _____ lbs./ kg (circle one)	<b>HEIGHT:</b> _____ ft. in./ cm (circle one)	
	<b>Measurement (inches)</b>	<b>Recommended Wheelchair Dimensions (inches)</b>
<b>Hip Width:</b> (straight line) or widest part of body in sitting		<b>Seat Width:</b>
<b>Thigh Length:</b> (straight line) from back of buttocks to back of knee		<b>Seat Depth:</b>
<b>Lower leg length:</b> (straight line) from back of knee to bottom of heel		<b>Seat to Floor Height:</b>
<b>Back height:</b> Sitting surface to axilla		<b>Back Height:</b>

**APPLICANT MEASUREMENTS – RANGE OF MOTION (ROM) AVAILABLE FOR SEATING**

<b>HIP ROM R:</b> _____ <b>L:</b> _____	<b>KNEE ROM R:</b> _____ <b>L:</b> _____	<b>ANKLE ROM R:</b> _____ <b>L:</b> _____
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**WHEELCHAIR FEATURES – SELECT ALL THAT APPLY**

ARMRESTS	LEG RESTS	FOOTPLATES	BACK CANES	ANTI-TIPPERS	WHEEL LOCK EXTENSIONS	HEADREST
<input type="checkbox"/> Single Post, height adjustable <input type="checkbox"/> Standard <input type="checkbox"/> Low <input type="checkbox"/> Dual Post <input type="checkbox"/> height adjustable <input type="checkbox"/> flip back	<input type="checkbox"/> 60 degree <input type="checkbox"/> 70 degree <input type="checkbox"/> 80 degree <input type="checkbox"/> 90 degree <input type="checkbox"/> Contracture System* <input type="checkbox"/> Elevating*  Set leg rest length to: (inches) _____	<input type="checkbox"/> Composite <input type="checkbox"/> Angle adjustable* <input type="checkbox"/> Aluminum* <i>(*only on ELR)</i>	<input type="checkbox"/> Fixed Height <input type="checkbox"/> Height adjustable <input type="checkbox"/> Reclining* <input type="checkbox"/> Dynamic (OTP)	<input type="checkbox"/> No* <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> No* <input type="checkbox"/> Yes
<b>ARM PAD</b>						
<input type="checkbox"/> Desk Length <input type="checkbox"/> Full Length						

**JUSTIFICATION FOR ANY ITEMS ABOVE MARKED "J" ON THE ORDER FORM OR WITH AN ASTERISK ABOVE:**

  
  
  
  
  
  
  
  
  
  

**PLEASE PROVIDE BILLING INSTRUCTIONS TO SMD REGARDING ANY ITEMS MARKED "OTP" ON THE ORDER FORM OR ABOVE:**

**PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:**

- The applicant is aware that SMD Wheelchair Services will only provide ONE mobility device per client.
- I have reviewed the SMD Equipment Loan Agreement with the Applicant and/or Representative

**Prescriber's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## EQUIPMENT LOAN AGREEMENT

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

1. I am entitled to use the equipment while I am a full time resident of Manitoba. If I move outside of Manitoba, I will return the equipment before leaving the province or purchase the equipment.
2. If I move within Manitoba, I will promptly report my new address and telephone number to the Manitoba Wheelchair Program.
3. I will only use the equipment for my personal mobility.
4. I will not sell, loan or allow any other person to use the equipment.
5. I will store the equipment in a secure, heated and dry indoor space to avoid damage or loss. If the equipment is damaged or lost because of failure to comply with safe storage, I will be required to pay the cost of repair or replacement.
6. I am responsible to use the equipment with reasonable care, keep it clean and regularly maintained. If the equipment is damaged or lost due to misuse I will be required to pay the cost of repair or replacement. The MB Wheelchair Program recommends that the wheelchair be added to the client's homeowner's / tenant's insurance policy.
7. I will not remove the permanent identification sticker attached to the equipment.
8. I will make the equipment available for servicing as necessary.
9. The Manitoba Wheelchair Program will have no responsibility for equipment repairs outside of Manitoba.
10. 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 at least 6 months before admission to the Personal Care Home.
11. The Manitoba Wheelchair Program may re-assess my eligibility for the equipment at anytime.
12. I will promptly return the equipment to the Manitoba Wheelchair Program if I a) am no longer eligible under the Manitoba Wheelchair Program OR b) no longer need the equipment OR c) fail to observe the terms of this agreement. I recognize that taking care of the equipment and returning it when I no longer need it will benefit other people. If the equipment is not returned, I will pay the depreciated value to replace the equipment.
13. 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.

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. SMD promises to treat your personal information in a secure and reasonable fashion while providing you with the highest level of professional service.

- I have read and understand the terms of the above Equipment Loan Agreement. I am legally bound by the terms and accept the loan of the equipment on these terms.
- I authorize SMD Wheelchair Services to disclose my personal health information contained in my wheelchair Application to authorized personnel for the sole purpose of processing my wheelchair request

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If client cannot write, a **LEGAL REPRESENTATIVE** may sign on behalf of the client below:

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Relationship to Client:** \_\_\_\_\_

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