SOCIETY FOR MANITOBANS WITH DISABILITIES – WHEELCHAIR SERVICES
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
Phone (204) 975-3250 Fax (204) 975-3240 Toll Free 1-800-836-5551

MANUAL WHEELCHAIR RENTAL APPLICATION
CATEGORY 2A - NIHB FUNDED CLIENTS ONLY

Note: Illegible or incomplete application forms will be returned to the prescriber

ANTICIPATED USE OF WHEELCHAIR: ☐ **TEMPORARY, LESS THAN SIX MONTHS**

PRIORITY LEVEL OF APPLICATION

☐ **REGULAR:** Applicant requires the wheelchair part time

☐ **URGENT:** Applicant requires the wheelchair full time and has no other means of mobility and/or is in hospital*.

Currently in hospital: ☐ YES ☐ NO Discharge Date: _____ Discharge Location*: _____
***Note:** Prescribing therapist must inform SMD if there is a change in discharge location (i.e. PCH, Chronic Care)

Delivery Instructions (if different than home address):_____

DEMOGRAPHICS (PLEASE PRINT)

FIRST NAME	**LAST NAME**	
DATE OF BIRTH (MM/DD/YYYY)	**GENDER** male female	**PHIN**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

Residence is a PCH or institution: ☐ YES ☐ NO Applicant is paneled/ will be paneled to PCH: ☐ YES ☐ NO

NEXT OF KIN (MUST BE A MANITOBA RESIDENT)

FIRST NAME	**LAST NAME**	**RELATIONSHIP TO APPLICANT**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

FUNDING INFORMATION

☐ **NON INSURED HEALTH BENEFITS** 10-digit number: _____

☐ **NIHB Loan Agreement attached**

☐ The prescriber has verified the applicant is not eligible WCB, MPIC, Victim's Services funding and/or is not a ward of Child & Family Services

PRESCRIBER INFORMATION

☐ **OCCUPATIONAL THERAPIST** ☐ **PHYSIOTHERAPIST** ☐ **OTHER:** _____

FIRST NAME	**LAST NAME**	**FACILITY NAME**
REGISTRATION #	**PHONE**	**FAX**
ADDRESS	**CITY**	**POSTAL CODE**
SIGNATURE: _____		**DATE**

MEDICAL DIAGNOSES AND FUNCTIONAL IMPLICATIONS RELATED TO NEED FOR WHEELCHAIR

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WEIGHT-BEARING STATUS – COMPLETE ONLY IF APPLICABLE

INDICATE LENGTH OF TIME CLIENT IS ANTICIPATED TO BE NON OR PARTIAL WEIGHT-BEARING
NOTE: ***IF WHEELCHAIR IS BEING PRESCRIBED DUE TO A FRACTURE, OUTLINE WEIGHT BEARING RESTRICTIONS, DATE OF ONSET AND WHERE INJURY OCCURRED***

PRESCRIPTION

☐ **2A: BREEZY EASY CARE 4000** **NOTE: APPLICANT'S WEIGHT MUST NOT EXCEED 250LBS.**

ASSESSMENT FINDINGS: USAGE PROFILE & PROPULSION STATUS

☐ **Part Time User (3-6 hours per day)**		☐ **Full Time User (6+ hours per day)**
☐ **Attendant Assist** *(does not propel, pushed at all times)*	☐ **Partially Independent** *(Requires assist in some environments/ outdoors or for longer distances)*	☐ **Independent** *(propels independently in all environments)*

APPLICANT MEASUREMENTS

CURRENT WEIGHT: _____ lbs./ kg (circle one)	**HEIGHT: _____ ft. in./ cm (circle one)**

	Information provided in this application must reflect applicant's current measurements	**Measurement (inches)**
MEASUREMENTS	**Hip Width**: (straight line) or widest part of body in sitting	
	Thigh Length: (straight line) from back of buttocks to back of knee	
	Lower leg length: (straight line) from back of knee to bottom of heel	
	Back height: Sitting surface to axilla	

WHEELCHAIR PARAMETERS

SEAT WIDTH	☐ **16"**	☐ **18"**	☐ **20"**
SEAT DEPTH	☐ **16"** ☐ **18"**	☐ **16"** ☐ **18"**	☐ **18"**
SEAT HEIGHT	☐ **17.75"** ☐ **19.75"**	☐ **17.75"** ☐ **19.75"**	☐ **19.75"**
BACK HEIGHT	☐ **16"** ☐ **18"**	☐**16"** ☐ **18"**	☐ **16"** ☐ **18"**

WHEELCHAIR ACCESSORIES

HEIGHT ADJUSTABLE FLIP BACK ARMREST	**LEG RESTS w/ composite footplates**	**WHEEL LOCK EXTENSIONS**	**ANTI-TIPPERS**
☐ **Full length**	☐ **70 degree**	☐ **No**	☐ **No**
☐ **Desk length**	☐ **Elevating** **Justification:**	☐ **Yes** ☐ **Right** ☐ **Left**	☐ **Yes** **Justification:**

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **Prescribed wheelchair will fit in applicant's home environment**

☐ **NIHB Equipment Agreement and Privacy Statement attached**

Prescriber's Signature _____ **Date** _____

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EQUIPMENT LOAN AGREEMENT

NIHB Equipment Agreement and Privacy Statement

The equipment on loan to you by the Manitoba Wheelchair Program and funded through Non Insured Health Benefits (NIHB).

Terms of acceptance for rental equipment funded through NIHB:

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.
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.
6. I am responsible to use the equipment with reasonable care, keep it clean and regularly maintained.
7. If the equipment is lost or stolen, I will contact NIHB.
8. I will not remove the permanent identification sticker attached to the equipment.
9. I will make the equipment available for servicing as necessary.
10. The Manitoba Wheelchair Program will have no responsibility for equipment repairs outside of Manitoba.
11. **At the end of the rental period, I will return my wheelchair to the Manitoba Wheelchair Program, 1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7.**

The Personal Health Information on this application is treated in compliance with "The Personal information Protection and Electronic Act." In order to serve you better we may need to share your 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 rental equipment agreement. I am legally bound by the terms and accept 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's Signature	Witness Signature	Witness Name (print)	Date