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

# POWER POSITIONING DEVICE APPLICATION

## PEDIATRIC AND ADULT

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

☐ **New Application** ☐ **Exchange Application**
**Reason for Exchange:** _____

☐ **POWER APPLICATION ALSO SUBMITTED – PROVIDE APPLICANT'S FIRST AND LAST NAME AND SKIP TO PAGE 2**

| **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

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):** _____

| **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** |

**THIRD PARTY FUNDING INFORMATION (COMPLETE AREAS THAT APPLY)**

☐ **EMPLOYMENT & INCOME ASSISTANCE**
Case Number**:** _____

☐ **NON INSURED HEALTH BENEFITS**
☐ **NIHB Loan Agreement attached**
10-digit number: _____

☐ 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/OR FUNCTIONAL IMPLICATIONS REQUIRING USE OF POWER WHEELCHAIR**

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## ELIGIBILITY CRITERIA – THERAPIST CONFIRMS THE FOLLOWING CONDITIONS APPLY

***Note:*** *Request for power tilt, power recline, or power elevating leg rests should not be considered where the purpose is solely for pain management, to facilitate transfers, swallowing, and/or rest.*

### POWER TILT OR POWER RECLINE

☐ Applicant is a full time user of their power wheelchair (6+ hours per day) and/or meets eligibility criteria for a power wheelchair via the SMD Wheelchair Program.

☐ Non ambulatory

☐ Applicant has cognitive capacity, hand function and/or physical ability to tilt or recline at regular intervals throughout the day and/or caregiver support to cue for same.

☐ Assessments and equipment trials completed to date demonstrate that static seating alone does not adequately address applicant's postural or skin integrity needs. *(provide justification below)*

☐ Assessment results reveal the application of tilt OR recline is required for the following reasons: *(check all that apply and provide justification below and pg. 4)*

- ☐ **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)*
- ☐ **Physiologic Function** *(e.g. suctioning or vent care, air exchange, bowel/bladder management, hypotension management)*
- ☐ **Other** _____

### POWER TILT AND POWER RECLINE

☐ Assessments completed to date demonstrate that power tilt or power recline alone is not an adequate solution to address issues as per above *(justification provided below and pg. 4).*

### POWER ELEVATING LEG RESTS ***Note:*** *Power elevating leg rest(s) will not be provided to manage general edema.*

☐ Decrease in lower extremity swelling due to chronic edema in lower extremities. **Objective trial data must be provided.**

☐ Individual is unable to independently operate manual leg rests AND requires dynamic elevation of lower extremities to manage orthopedic issues and/or tone *(justification required below and pg. 4).*

## PRESCRIPTION – SELECT ALL THAT APPLY

| | | |
|---|---|---|
| ☐ **POWER TILT** | ☐ **POWER RECLINE** | ☐ **POWER ELEVATING LEGRETS** |

**RATIONALE FOR PRESCRIBED POWER POSITIONING DEVICE(S):** *(**Must be completed** – supporting documentation may accompany this application form if necessary)*

### POWER POSITIONING DEVICE ACTIVATION

| | | |
|---|---|---|
| ☐ **THROUGH THE JOYSTICK** | ☐ **SEPARATE SWITCH*** | ☐ **SPECIALTY DRIVE CONTROL*** |

**RATIONALE/JUSTIFICATION FOR OPTIONS MARKED WITH ASTERISK:**

**POWER POSITIONING DEVICE TO BE INSTALLED ON APPLICANT'S CURRENT POWER WHEELCHAIR** ☐ **Yes** ☐ **No***
**IF NO - SMD: POWER WHEELCHAIR APPLICATION MUST ACCOMPANY THIS APPLICATION*

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## 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 (Include description of limitations or shortcomings of current set up that negatively impact the applicant's function or mobility)**

**DESCRIBE APPLICANT'S POSTURE IN CURRENT SEATING SYSTEM (Include notable asymmetries at hips, knees, trunk, head/neck)**

**DESCRIBE RANGE OF MOTION LIMITATIONS CURRENTLY AFFECTING APPLICANT'S POSTURE IN SITTING**

| | | |
|---|---|---|
| **HIP ROM R: _____ L: _____** | **KNEE ROM R: _____ L: _____** | **ANKLE ROM R: _____ L: _____** |

**DESCRIBE POSTURAL AND/OR SKELETAL CONSIDERATIONS THAT SUPPORT THE USE OF TILT AND/OR RECLINE**

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## FUNCTIONAL STATUS

| SITTING TOLERANCE | Total Sit time currently tolerated: _____ | Desired Sit Time: _____ |
|---|---|---|

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

**DESCRIBE HOW THE USE OF TILT AND/OR RECLINE AND/OR POWER ELEVATING LEG RESTS WILL ENHANCE THE APPLICANT'S GLOBAL FUNCTION:**

## PHYSIOLOGIC FUNCTION – COMPLETE IF APPLICABLE

**DESCRIBE HOW THE USE OF A POWER POSITIONING DEVICE IS REQUIRED FOR OPTIMAL PHYSIOLOGIC FUNCTION** *(Include Objective Data if available; e.g. bowel/bladder management, orthostatic hypotension management, arousal, etc.)*

## RESPIRATORY STATUS – COMPLETE IF APPLICABLE

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

## ORTHOPEDIC CONSIDERATIONS – COMPLETE IF APPLICABLE

**DESCRIBE HOW THE USE OF A POWER POSITIONING DEVICE WILL ADDRESS ANY ORTHOPEDIC CONCERNS** *(e.g. tone management, range of motion limitations)*

| HEADREST – CONFIRM IF REQUIRED | ☐ YES | ☐ NO |
|---|---|---|

## PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **The applicant is aware that SMD Wheelchair Services may require their current power wheelchair for at least ONE business day to install the power positioning device to their current power wheelchair.** *(If applicable)*

☐ **I have reviewed the SMD Equipment Loan Agreement with the Applicant and/or Representative**

**Prescriber's Signature** _____ **Date** _____

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# 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 any time.
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:** _____