SOCIETY FOR MANITOBANS WITH DISABILITIES – WHEELCHAIR SERVICES
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
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(SMD-003) Category 3 MANUAL WHEELCHAIR APPLICATION

Write legibly and provide ALL requested information

☐ **NEW APPLICATION** ☐ **EXCHANGE APPLICATION** (Without reasonable justification exchanges will not be considered)

Reason (s) for exchange ______________________________

APPLICANT

First Name (print)	Last Name	
Date of Birth (mm/dd/yyyy)	Gender ☐ male ☐ female	PHIN #
Home Address	City	Postal Code
Mailing Address if different from above		
Home Phone	Cell Phone	e-mail

Residence is a PCH or institution ☐ yes ☐ no   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)

BILLING INFORMATION

Applicant is eligible to receive funding for prescribed wheelchair from any of these funding sources

- ☐ Medical Services funding   provide NIHB # ____________________
- ☐ Veterans Affairs funding   provide DVA # ____________________
- ☐ Employment and Income Assistance   provide EIA # ______________________

Full name of EIA Case Coordinator ________________________________Office address__________________________

Telephone ____ Fax __________________________________

NEXT OF KIN (Must be residing in Manitoba)

First Name (print)	Last Name	Relationship to applicant
Home Address	City	Postal Code
Home phone	Cell phone	e-mail

PHYSICIAN (complete this section only if client is funded by NIHB)

First Name (print)	Last Name	Signature
Registration #	Phone	Fax
Address	City	Postal Code

PRESCRIBER (must be an Occupational Therapist or Physiotherapist registered to practice in Manitoba)

First Name (print)	Last Name	Position
Address	City	Postal Code
e-mail	Phone	Fax

ELIGIBILITY

Primary Diagnosis and date of onset

Other presenting conditions related to the need for the prescribed wheelchair

Transfers ☐ independently ☐ with assist ☐ requires mechanical lift

Ambulates ☐ independently ☐ With standby supervision ☐ With assist ☐ Unable to walk

Distance ___________meters / feet Requires walking aid ☐ yes ☐ no ____________________

Propulsion ☐ independent propeller ☐ partially independent propeller ☐ attendant assist

Method of propulsion ☐ using arms only ☐ using feet only ☐ using both

Describe position in the current wheelchair	Can client reposition?	Comment
Pelvis ____________________	☐ yes ☐ no	____________________
Hips ____________________	☐ yes ☐ no	____________________
Knees ____________________	☐ yes ☐ no	____________________
Feet ____________________	☐ yes ☐ no	____________________
Trunk ____________________	☐ yes ☐ no	____________________
Shoulders ____________________	☐ yes ☐ no	____________________
Head/neck ____________________	☐ yes ☐ no	____________________
Arms ____________________	☐ yes ☐ no	____________________
Other ____________________	☐ yes ☐ no	____________________

Trunk control ☐ dependent ☐ hands dependent sitter ☐ hands free only ☐ hands free and can shift weight out of midline

Based on mat assessment describe abnormal tone that affect the applicant's posture in the wheelchair.

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Based on mat assessment describe limitations in range of motion for seating that affect the applicant's posture in the wheelchair.

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____

____

History of pressure sore? ☐ yes ☐ no If **yes**, where? _______________ stage__________ when_____________

Current skin integrity ☐ intact
☐ skin breakdown stage __________ Where? ______________________________
Since when ___________________________

Are skin checks done? ☐ yes ☐ no If **no**, why not? ______________________________________

If **yes**, how often is this done? ____________________ By whom? ______________________________

Sensation is ☐ intact ☐ impaired Impaired where? ______________________________

Bowel & Bladder ☐ continent of bladder ☐ continent of bowel ☐ incontinent of bladder ☐ incontinent of bowel

Does applicant weight shift in the seated position? . ☐ Yes ☐ No

If **yes**, ☐ independently ☐ with assist
If independently, how is this done? ______________________________ How often? _________
If done with assist, who provides assistance? ________________________ How often? ___________

If **no**, why not? ____

Maximum time applicant is able to tolerate sitting up in the wheelchair _______________

What limits this? ____

Applicant requires the use of the wheelchair ___________ hours a day

Additional comments. Include pressure mapping result if available.________________________________

Describe current wheelchair ____

____

Describe current seating ____

____

Describe limitations of the current wheelchair **and** seating in meeting the applicant's mobility and seating needs.

____

____

____

Client will use the wheelchair ☐ Indoors only ☐ Outdoors only ☐ Indoors and outdoors

Client lives ☐ alone ☐ with spouse ☐ other ______________________

Client has caregiver support to regularly tilt the wheelchair ☐ yes ☐ no

Entrance has a ☐ lift with railing ☐ Ramp with railing ☐ level entrance ☐ Stairs

If entrance is not wheelchair accessible, describe plan to ensure client safety when entering and exiting the house?

____

Projected goals for requested wheelchair (SMART– specific, measurable, attainable, relevant, time related)

1. ____

2. ____

3. ____

WHEELCHAIR SPECIFICATIONS

Category requested ☐ 3A ☐ 3B
Model of 3A wheelchair requested ☐ Quickie SR45 ☐ Quickie Iris

NOTE Because these two tilt chairs have many similar/comparable features, the SR 45 is commonly selected and assigned. If you selected SR45, fill out the SR45 spec sheet (download from the SMD website), then proceed to #2 below. If you selected the Quickie Iris, proceed to #1 below. Fill out the Quickie Iris spec sheet (download from the SMD website). Submit completed spec sheet with this application.

Contact the SMD Occupational Therapist if applicant's weight exceeds the weight capacity of category 3 wheelchairs available in the program .

1) **Justification for Quickie Iris**_________ ____

____

____

____

____

2) **Justification for items that have (2) beside it in the spec sheet**

Feature	Justification- include data from mat assessment
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________

CURRENT weight ________ lbs. height _______feet weight likely to change? ☐ yes ☐ no If yes, explain________________________

Must provide applicant's actual measurements	Wheelchair dimensions (without seating system)
hip width or widest part of the body _______ inches	**Wheelchair Seat width _____ inches**
thigh length _______ inches	**Wheelchair Seat depth _____ inches**
leg length ______ inches	**W/chair Seat height ______ inches Leg rest length _____ inches**
Back height ________	**Wheelchair Back Height _________ inches**

Arm rests ☐ Full length ☐ Desk length
Legrests Standard 70 degrees ☐ right ☐ left Other than 70 degrees, specify _______________________ ☐ right ☐ left
Footplates Composite ☐ right ☐ left Other than composite , specify ___________________________ ☐ right ☐ left
Headrest ☐ yes ☐ no (applicant will purchase own headrest)

Delivery instructions if different from client's address:

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Prescribed wheelchair will fit in client's home environment. ☐ yes ☐ no
Client has been informed that the tilt wheelchair will not come with a backrest and seat cushion. ☐ yes
Client's has been informed that the purchase of the backrest and seat cushion is their responsibility. ☐ yes
Client and caregiver have been instructed on the benefits of regular use of tilt. ☐ yes
Client and caregiver have been informed that the prescribed wheelchair does not collapse for transport. ☐ yes
Client and caregiver have been informed that a second collapsible wheelchair will not be provided. ☐ yes
Client has been informed that they are to return their current wheelchair if they have one on loan from the program. ☐ yes
Information provided in this application is based on client's current measurements. ☐ yes

Prescriber's Signature ___________________________________ Date Completed___________________________

EQUIPMENT LOAN AGREEMENT AND PRIVACY STATEMENT

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

I accept the loan of the equipment on the following terms:

1. I am only entitled to use the equipment while I am a full time resident of Manitoba. If I move outside Manitoba, I will return the equipment before I leave 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 place 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 the 6 months before I enter the personal care home.
11. The Manitoba Wheelchair Program may re-assess my need for the equipment at any time.
12. I will promptly return the equipment to the Manitoba Wheelchair Program if I am no longer eligible under the Manitoba Wheelchair Program or if I no longer need the equipment or if I do not observe the terms of this agreement. I realize 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's signature	Witness signature	Witness name (print)	Date

If client cannot write, a LEGAL REPRESENTATIVE may sign above on behalf of the client.
If you are signing as a legal representative, complete information below.

_________________________	____________________________	_____________________	_________________
Printed name and signature	Relationship to applicant	Address	Date