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

(SMD-007) POWER DYNAMIC POSITIONING DEVICE APPLICATION

Write Legibly and provide all requested information.

NOTE: If applicant has an SMD Invacare power chair. Call SMD if SMD-006 is also required.
If applicant does not have an SMD power chair, submit SMD-005 with this application.
If submitting SMD-005 with this application, check here ☐, enter applicant's first and last name then proceed to eligibility section on page 2.
If submitting SMD-006 with this application, check here ☐, enter applicant's first and last name then proceed to power chair usage below.

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 / institution ☐ yes ☐ no Is paneled / will be paneled to a 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 location ______________________________
Telephone ____________________________ Fax ________________________________

NEXT OF KIN (Must be residing in Manitoba)

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

PHYSICIAN (Must be completed only if applicant is funded by NIHB)

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

MEDICAL STATUS

Primary Diagnosis **and** date of onset

Other presenting medical conditions related to the need for the power dynamic positioning device.

Is change in medical condition expected? ☐ yes ☐ no (explain)

POWER CHAIR USAGE

Applicant drives the current power chair independently ☐ yes ☐ no
Power chair is used ☐ mostly in the community ☐ mostly inside the home ☐ inside the home and community
Power chair is used ☐ as primary method of mobility (daily) ☐ 4-5 times a week ☐ 2-3 times a week ☐ once a week

Number of hours per day the power chair is used _______

ELIGIBILITY

Transfers ☐ independently
☐ with assist
☐ Client requires mechanical lift

Ambulates ☐ independently ☐ with standby supervision ☐ with assist ☐ unable to walk Distance ___________meters / feet

Describe applicant's 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 sitting posture in the wheelchair.

____

____

____

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

____

____

____

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

Current skin integrity ☐ intact
☐ skin breakdown stage _______ where ______________________

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

If **YES**, how often is this done? ______________________ By whom? ______________________

Sensation ☐ intact ☐ impaired Impaired where? ______________________

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

Does applicant weight shift in the seated position? . ☐ Yes ☐ No If **NO**, why not? ______________________

If **YES**, ☐ independently ☐ with assist

If done independently, how is this done? ______________________ How often? ______________________

If weight shift is done with assist, who provides assists? ______________________ How often? ______________________

Maximum time applicant sits in the wheelchair _________ What limits this? ______________________

Applicant requires the use of the wheelchair ____________ hours a day

Include pressure mapping result if available.______________________

Describe current power chair______________________

____

____

Describe current seating ______________________

limitations of current power chair and seating in meeting applicant's mobility and seating needs ______________________

____

____

If requesting POWER RECLINE ONLY, provide justification. ☐ **n/a**

____

____

____

If requesting POWER TILT **AND** POWER RECLINE ONLY, provide justification. ☐ **n/a**

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____

____

If requesting POWER ELEVATING LEG RESTS, provide justification. ☐ **n/a**

____

____

____

Client has knee ROM for elevating leg rests ☐ yes ☐ no   Manual ELR was trialed ☐ yes ☐ no

If yes, describe the outcome ____

If not, why not? ____

Projected goals for power dynamic positioning device (SMART - specific, measurable, attainable, relevant, time related)

1. ____

2. ____

3. ____

4. ____

POWER DYNAMIC POSITIONING DEVICE SPECIFICATIONS

Requesting ☐ Power tilt ☐ Power recline ☐ Power tilt **and** power recline ☐ Power elevating leg rests

Client will operate power positioning device through the ☐ joystick ☐ separate switch

Provide justification____

Headrest ☐ yes ☐ no (Applicant will purchase own headrest)

NOTE If submitting 005 or 006 with this application, check here ☐, proceed to last box below for your signature

CURRENT weight _____ lbs height _____ feet/in. Weight likely to change? ☐ yes ☐ no If yes, explain__________________________

Must provide client's actual measurements	Wheelchair specifications (without seating system)
Client's hip width or widest part body ______ inches.	**Wheelchair seat width ______ inches**
Client's thigh length ______ inches	**Wheelchair seat depth ______ inches**
Client's leg length ______ inches	**Wheelchair seat height ________ inches Leg rest length ________inches**
Client's Back height_______ inches	**Wheelchair back height _______ inches**

Applicant's hip flexion for seating ___________ Back / seat angle _________ Seat angle __________

Armrests Full length adjustable ☐ right ☐ left   Desk length adjustable ☐ right ☐ left

Front rigging

Center Pivot hanger

60˚ swing away (**RWD**) ☐ right ☐ left
70˚ swing away (**RWD & MWD**) ☐ right ☐ left
90˚ swing away (RWD) ☐ right ☐ left
Elevating leg rests (**RWD**) ☐ right ☐ left

Center Pivot footplates

☐ Composite
☐ Aluminum
☐ Angle adjustable

Center Mount hanger

☐ Center mount (**MWD**)
(maximum length is 12" and 15")

Center Mount footplates

☐ Small Footplates
☐ Medium Footplates
☐ Large Footplates
☐ One-piece footboard

Joystick ☐ right ☐ left

Is delivery to applicant's home address? ☐ yes ☐ no Deliver/ship to ____

NOTE Wheelchair Services will deliver to one address only

Client has been instructed on the benefits of regularly using the requested power dynamic positioning device. ☐ **yes** ☐ **no**

Prescriber ______________________________ Date__________________________

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