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-008) POWER DYNAMIC POSITIONING DEVICE EXCHANGE APPLICATION

Incomplete or illegible forms will be returned.

NOTE: If submitting SMD-006 with this application, check here ☐, enter applicant's first and last name then proceed to eligibility section below.

REASON(S) FOR EXCHANGE

CLIENT INFORMATION

First Name (Please 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 (Please 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)

☐ It is my opinion that provision of a power wheelchair is required to improve this applicant's functional status.

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.

Has there been a change in medical status since client received current power wheelchair? ☐ yes ☐ no If yes, please describe

ELIGIBILITY

Transfers ☐ independently
☐ with assist
☐ Client requires mechanical lift

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

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

Describe client'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	_____

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._____

_____

Operates power dynamic positioning device independently. ☐ yes ☐ no
Operates through ☐ joystick ☐ separate switch

Current usage

If applicant has POWER TILT, does applicant use it? ☐ yes ☐ no ☐ n/a

If **YES**, approximate # of times per day the chair is tilted _____ For how long? _____

What degree of tilt is used? _____ Reason(s) for using power tilt _____

If **not using power tilt**, why not? _____

If applicant has POWER RECLINE, does applicant use it? ☐ yes ☐ no ☐ n/a

If **YES,** approximate # of times per day the chair is reclined _____ For how long? _____

What degree of recline is used? _____ Reason(s) for using power recline_____

If **not using power recline**, why not? _____

If client has POWER ELEVATING LEG RESTS, does applicant use it? ☐ yes ☐ no ☐ n/a

If **YES**, approximate # of times per day the lower extremities are elevated _____ For how long? _____

Reason(s) for using power ELR _____

If **not using power ELR**,, why not? _____

Describe how the use of current ☐ power tilt ☐ power recline ☐ power ELR positively influenced the applicant's

Medical status _____

_____

skin integrity _____

_____

Current skin integrity ☐ intact ☐ Reddened areas_____ ☐ Open areas _____

posture in the wheelchair _____

_____

Functional performance _____

_____

Describe current chair_____

_____

Current seating _____

Describe limitations of current wheelchair and seating in meeting applicant's mobility and seating needs _____

_____

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

1. _____

   _____

2. _____

   _____

3. _____

   _____

4. _____

   _____

POWER DYNAMIC POSITIONING DEVICE SPECIFICATIONS

If applicant requires a different power dynamic positioning device **OR** adding a power dynamic positioning device, provide justification:

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

Justification _____

_____

If requesting power ELR, has knee ROM for ELR ☐ yes ☐ no Manual ELR was trialed ☐ yes ☐ no

Outcome of trial _____ If not trialed, why not? _____

Will operate power positioning device through the ☐ joystick ☐ separate switch

Justification _____

Headrest ☐ yes ☐ no (applicant will purchase own)

NOTE If submitting SMD- 006 with this application, check here ☐, then proceed to last box 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

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

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