SOCIETY FOR MANITOBANS WITH DISABILITIES – WHEELCHAIR SERVICES
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
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(SMD-009) POWER WHEELCHAIR / PDPD FOLLOW UP

.

CLIENT INFORMATION

First Name (Please print)	Last Name

SCRIPTOR'S INFORMATION

Name	Last Name	e-mail	Phone

A. POWER WHEELCHAIR REPORT ☐ n/a

Client uses the power wheelchair
☐ mostly in the community ☐ mostly inside the home ☐ inside the home AND community

Client uses the power wheelchair
☐ as the primary method of mobility (daily) ☐ 4-5 times a week ☐ 2-3 times a week ☐ once a week

Client uses the power wheelchair _____ hours per day

Client drives the power wheelchair independently and safely indoors ☐ yes ☐ no

If **NO** describe the problem _____

What is being done to resolve this _____

Client drives the power wheelchair independently and safely outdoors ☐ yes ☐ no

If no, describe the problem _____

What is being done to resolve this _____

Describe the effect of the power wheelchair on the client's participation in the following:

ADL (specify)_____

_____

IADL (specify) _____

_____

Childcare responsibilities _____

Employment _____

Education _____

Volunteer work _____

Medical appointments _____

Recreational activities (specify) _____

Power wheelchair can access entrance door ☐ yes ☐ no bedroom ☐ yes ☐ no bathroom ☐ yes ☐ no
Kitchen ☐ yes ☐ no other _____

Where is power wheelchair stored? _____

Who charges the batteries? _____ How often are they charged? _____

Manual wheelchair was returned to SMD ☐ yes ☐ no ☐ NA (client did not have a manual chair prior to power)

Additional comments _____

_____

_____

_____

B. POWER DYNAMIC POSITIONING DEVICE REPORT

Currently has ☐ power tilt ☐ power recline ☐ power tilt and power recline ☐ power elevating leg rests

Client can independently operate power dynamic positioning device. ☐ yes ☐ no

If no, describe the problem _____

Actual usage

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

If **yes**, approximate # of times per day the client tilts the chair _____

What degree of tilt is used? _____

Client's reason(s) for using power tilt _____

If **no**, client's reason(s) for <u>not</u> using power tilt _____

If client has **POWER RECLINE**, does aclient use it? ☐ yes ☐ no ☐ n/a

If **yes**, approximate # of times per day the client reclines the back of the power chair _____

client's reason(s) for using power recline_____

If **no**, client's reason(s) for not using power recline_____

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

If **yes**, approximate # of times per day the client uses the power ELR _____

client's reason(s) for using power ELR_____

If **no**, client's reason(s) for not using power ELR _____

LIST THE GOALS IDENTIFIED IN THE APPLICATION AND INDICATE OUTCOME.

Goals	Outcome	
# 1	☐ met **Comment**	☐ not met. **Comment**
# 2	☐ met **Comment**	☐ not met. **Comment**
# 3	☐ met **Comment**	☐ not met. **Comment**
# 4	☐ met **Comment**	☐ not met. **Comment**

Additional comments _____

_____

_____

_____

NOTE If it is demonstrated that the positioning device is meeting the goals identified in the application **and** usage is consistent with the program criteria, the system will be permanently loaned to the client. If the report indicates that the positioning device did not meet the goals identified in the application, the device will be recalled. The client can pursue options outside of the program.

Signature _____ Date_____