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-011) PEDIATRIC MANUAL WHEELCHAIR APPLICATION

Incomplete or illegible forms will be returned.

☐ **NEW APPLICATION** ☐ **EXCHANGE APPLICATION**

Reason (s) for exchange _____

_____

Without reasonable justification exchanges will not be considered.

CLIENT INFORMATION

First Name (Please print)	Last Name	
Date of Birth (mm/dd/yyyy)	Gender ☐ male ☐ female	PHIN #
Home Address	City	Postal Code
Home Phone	Cell Phone	

BILLING INFORMATION

Client is not eligible to receive funding for prescribed wheelchair from other funding sources ☐ **yes** ☐ **no**

Client is eligible for Medical Services funding ☐ yes ☐ no If yes, provide NIHB # _____

Client is eligible for Veterans Affairs funding ☐ yes ☐ no If yes, provide DVA # _____

Client is receiving Employment and Income Assistance ☐ yes ☐ no If yes, provide EIA # _____

EIA Case Coordinator _____ Office address _____

Telephone _____ Fax _____

NEXT OF KIN (Must be residing in Manitoba)

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

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

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

SCRIPTOR (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

ELIGIBILITY

Primary Diagnosis

Other presenting medical conditions related to the need for the wheelchair

Client can transfer in /out of the wheelchair ☐ independently ☐ with assist ☐ requires mechanical lift

Distance of <u>independent</u> ambulation

☐ unable to walk ☐ walks independently 0 – 25 meters (80 feet) ☐ walks independently 25 – 50 meters (160 feet)

Requires walking aid ☐ yes ☐ no specify _____

If able to propel, method of propulsion ☐ Using arms ☐ Using feet ☐ Using both

A. <u>Complete for all pediatric wheelchair requests</u>

<u>Check the box that appropriately describes the applicant</u>

☐ **Occasional user** *(use for outings, or when fatigued, will use more than once a week but less than 3 hours a day),*
Independent propeller or attendant assist .

☐ **Part time user** *(3-5 hours a day),*
Attendant assist. *Does not propel the wheelchair, is pushed all the time*.

☐ **Part time user** *(3-5 hours a day)***,**
Partially independent propeller. *Propels independently but requires assist some of the time.*

☐ **Part time user** *(3-5 hours a day)***,**
Partially independent propeller. *Propels independently but requires assist some of the time.*

☐ **Full time user** *(minimum of 6 hours a day)*
Attendant assist . *Client does not propel the wheelchair, is pushed all the time*.

☐ **Full time user** *(minimum of 6 hours a day),*
Partially independent propeller. *Propels independently but requires assist some of the time.*

☐ **Full time user** *(minimum of 6 hours a day)*
Independent propeller. *Propels independently within home environment and immediate outdoors. No assist required.*

B. <u>Complete only if client requires a tilt wheelchair.</u> Check box that appropriately describes the applicant

☐ Client cannot maintain a functional sitting position due to abnormal tone and posture cannot be supported with the addition of fixed seating alone.

☐ Client demonstrates a history of tissue trauma and or significant risk of skin breakdown due to unrelieved pressure and inability to weight shift independently. Skin integrity cannot be maintained with the addition of fixed seating alone.

Projected goals for manual dynamic tilt wheelchair (SMART– specific, measurable, attainable, relevant, time related)

1. _____

_____

2. _____

_____

3. _____

_____

WHEELCHAIR SPECIFICATIONS

Model of wheelchair requested ☐ Zippie GS ☐ Zippie TS ☐ Zippie Iris

NOTE

If requesting Zippie GS, fill out the Zippie GS spec sheet (download from the SMD website), then proceed to client's height below.

If requesting Zippie TS, fill out the Zippie TS spec sheet (download from the SMD website), then proceed to #2 below.

If requesting Zippie Iris, complete #1 and #2 below. Fill out the Zippie Iris spec sheet (download from the SMD website)/

Fax spec sheet and application to SMD.

1. Justification for Zippie Iris _____

   _____

2. Provide justification for requested feature that has (2) beside it on the spec sheet

Feature	Justification
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Client's height _____ ☐ feet/inches ☐ cm Client's current weight _____ ☐ lbs. ☐ kg

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**

Arm rests ☐ Full length ☐ Desk length

Legrests Standard 70 degrees ☐ right ☐ left

Other than 70 degrees, specify _____

Footplates Composite ☐ right ☐ left

Other than composite , specify _____

Delivery instructions if different from client's address _____

Information provided in this application is based on client's current measurements. ☐ **yes**

Prescribed wheelchair will fit in client's home. ☐ **yes** ☐ **no**

Client's home entrance is ☐ level ☐ has a ramp ☐ has a lift ☐ stairs

If client's home entrance is not level and has no ramp, how will client safely enter and exit place of residence? _____

_____

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
_____	_____	_____	_____