Manitoba Wheelchair Program
(MWP)
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
Phone (204) 975-3250 Fax (204) 975-3240 Toll Free 1-800-836-5551

POWER POSITIONING DEVICE APPLICATION

PEDIATRIC AND ADULT

(Note: 1st page not required if submitting with Power Wheelchair Application Form)

☐ **NEW APPLICATION:** Client requires a wheelchair for permanent medical needs/longer than 6 months.	☐ **EXCHANGE APPLICATION** **REASON FOR EXCHANGE:**

☐ **REGULAR:** Applicant requires the wheelchair part-time/has an interim wheelchair to use

☐ **URGENT:** Applicant has no other means of mobility and is at increased safety-risks without wheelchair: **Note**: may be provided with a recycled or substituted equipment if it meets basic and essential mobility needs.

CURRENTLY IN HOSPITAL? ☐ **YES** ☐ **NO** **Discharge Date:** _____ **Discharge Location:** _____

Delivery Instructions - If different than home address:

CLIENT DEMOGRAPHICS (PLEASE PRINT)

FIRST NAME	**LAST NAME**	
DATE OF BIRTH (MM/DD/YYYY)	**GENDER**	**PHIN**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

☐ The prescriber has verified the applicant is not eligible for WCB, MPIC, Victim's Services funding and/or is not a ward of Child & Family Services.

☐ The client resides in a facility (e.g., PCH). Must provide EIA# if applicable:

NEXT OF KIN (MUST BE A MANITOBA RESIDENT)

FIRST NAME	**LAST NAME**	**RELATIONSHIP TO APPLICANT:**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

PRESCRIBER INFORMATION

☐ **OCCUPATIONAL THERAPIST**	☐ **PHYSIOTHERAPIST**	☐**OTHER (SPECIFY):**
FIRST NAME	**LAST NAME**	**REGISTRATION #**
ADDRESS	**CITY**	**POSTAL CODE**
EMAIL	**PHONE**	**FAX**

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DIAGNOSIS AND/OR FUNCTIONAL IMPLICATIONS REQUIRING USE OF PWC

RECOMMENDED POWER POSITIONING DEVICE (S):

☐ **Power Tilt**	☐ **Power Recline**	☐ **Power Elevating Leg Rests in combination with Power Tilt/Power Recline** **Note:** Power elevating leg rest(s) will not be provided to manage general edema.

Applicant's Eligibility:

REQUIREMENT: ☐ The applicant is a full-time user of current power wheelchair (6+ hours per day) and/or meets eligibility criteria for a power wheelchair via the Manitoba Wheelchair Program.

REQUIREMENT: ☐ Applicant has cognitive capacity, hand function and/or physical ability to operate the power actuators as per best practice standards/regular intervals throughout the day and/or caregiver support to cue for same.

REQUIREMENT: ☐ Assessments and equipment trials completed and demonstrate that static seating alone does not *adequately* address applicant's postural or skin integrity needs *(provided justification in the applicable sections).*

Note: *Request for power tilt, power recline, or power elevating leg rests will not be considered where the purpose is solely for pain management, to facilitate transfers, swallowing, and/or rest.*

For **Power Tilt or Power Recline ONLY** (*check all that apply and provide justification in the applicable sections*):

- ☐ **Pressure Management** *(e.g., pressure redistribution, wound management)*
- ☐ **Postural Support** *(e.g., eye gaze, trunk extension, stability in chair)*
- ☐ **Functional Optimization** *(e.g., improve sitting tolerance, improve posture for feeding/swallowing)*
- ☐ **Physiologic Function** *(e.g., suctioning or vent care, air exchange, bowel/bladder management, hypotension management)*
- ☐ **Other:**

For **Power Tilt AND Power Recline:**

- Assessments and equipment trials completed to-date demonstrate that power tilt or power recline alone is not an adequate solution to address issues as per above *(provided justification in the applicable sections).*
- Objective results obtained for improvements in all functions OR provide supporting documentation if applicable (e.g., physician's support letter/recommendations and pictures if available).

For **Power Elevating Leg Rests:**

- Assessments and equipment trials provide objective data in decreasing lower extremity swelling due to chronic edema. Provide supporting documentation if applicable (e.g., physician's support letter/recommendations and pictures if available).
- Individual is unable to independently operate manual leg rests AND requires dynamic elevation of lower extremities to manage orthopedic issues and/or tone *(provided justification in applicable sections).*

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RATIONALE FOR PRESCRIBED POWER POSITIONING DEVICE(S): *(**Must be completed** – supporting documentation may accompany this application form if necessary)*

POWER POSITIONING DEVICE ACTIVATION

☐ **THROUGH THE JOYSTICK**	☐ **SEPARATE SWITCH* - A OR B.** **A) TOGGLE** **B) PUSH BUTTONS**	☐ **SPECIALTY DRIVE CONTROL***

RATIONALE/JUSTIFICATION FOR OPTIONS MARKED WITH ASTERISK:

POWER POSITIONING DEVICE TO BE INSTALLED ON APPLICANT'S CURRENT POWER WHEELCHAIR ☐ **Yes** ☐ **No***
**IF NO - MWP: POWER WHEELCHAIR APPLICATION MUST ACCOMPANY THIS APPLICATION*

PRESSURE MANAGEMENT AND SKIN INTEGRITY EVALUATION

Current Skin Integrity: ☐ **INTACT** ☐ **HISTORY OF BREAKDOWN** ☐ **PRESSURE INJURY**	**Describe:**

CURRENT PRESSURE MANAGEMENT STRATEGIES:

☐ **CAN THE APPLICANT <u>EFFECTIVELY</u> REPOSITION FOR THE PURPOSE OF PRESSURE MANAGEMENT (I.E. OFFLOADING)?**

Describe:

☐ **IF APPLICANT IS UNABLE TO EFFECTIVELY REPOSITION FOR THE PURPOSE OF PRESSURE MANAGEMENT, WHAT ALTERNATE STRATEGIES HAS THE APPLICANT/CAREGIVER INCORPORATED TO ADDRESS PRESSURE MANAGEMENT CONCERNS?**

☐ **DOES THE APPLICANT AND/OR THEIR CAREGIVERS PERFORM REGULAR SKIN CHECKS?**

Describe:

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FUNCTIONAL SEATING AND POSITIONING

Applicant's Postures for PWC SEATING:

- **Hip Flexion – Extension ROM:** L _____ R _____
- **Hip Abduction-Adduction ROM:** L _____ R _____
- **Pelvic Position:** ☐ Posterior Tilt ☐ Anterior Tilt ☐Neutral
- **Pelvic Obliquity:** ☐Left High ☐ Right High ☐Neutral
- **Knee flexion – Extension ROM:** L _____ R _____
- **Ankle Dorsi-Plantar Flexion ROM:** L _____ R _____

Prescriber has evaluated applicant's seating system based on best practice standards of ~every 5 years or with change in function. Current System:

☐ **Cushion type/name:**

☐ **Backrest type/name:**

☐ **Other/Positioning Components:**

☐ **DESCRIBE CURRENT ISSUES WITH SEATING SYSTEM (Include description of limitations or shortcomings of current set up that negatively impact the applicant's function or mobility):**

☐ **DESCRIBE APPLICANT'S POSTURE IN CURRENT SEATING SYSTEM (Include notable asymmetries at hips, knees, trunk, head/neck):**

☐ **DESCRIBE RANGE OF MOTION LIMITATIONS CURRENTLY AFFECTING APPLICANT'S POSTURE IN SITTING:**

FUNCTIONAL STATUS

SITTING TOLERANCE: Total Sit time currently tolerated: **Desired Sit Time:**

DESCRIBE FACTORS THAT LIMIT THE APPLICANT'S SIT TIME:

DESCRIBE HOW THE USE OF THE PRESCRIBED POWER POSITIONING DEVICE WILL ENHANCE THE APPLICANT'S GLOBAL FUNCTION:

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PHYSIOLOGIC FUNCTION – COMPLETE IF APPLICABLE

DESCRIBE HOW THE USE OF A POWER POSITIONING DEVICE IS REQUIRED FOR OPTIMAL PHYSIOLOGIC FUNCTION *(Include Objective Data if available, e.g. bowel/bladder management, orthostatic hypotension management, arousal, etc.):*

RESPIRATORY STATUS – COMPLETE IF APPLICABLE

DESCRIBE HOW THE USE OF A POWER POSITIONING DEVICE WILL IMPROVE APPLICANT'S AIR EXCHANGE/ RESPIRATORY STATUS: *(Include Objective Data if available)*

ORTHOPEDIC CONSIDERATIONS – COMPLETE IF APPLICABLE

DESCRIBE HOW THE USE OF A POWER POSITIONING DEVICE WILL ADDRESS ANY ORTHOPEDIC CONCERNS *(e.g. tone management, range of motion limitations)*

STANDARD HEADREST & HARDWARE – CONFIRM IF REQUIRED:

☐ **YES** ☐ **NO**

☐ **N/A** - Clients with DHSU/EIA funding ONLY, if standard options are not appropriate; must request alternate options with the seating/positioning components request to DHSU.

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ The applicant is aware that the MWP may require their current power wheelchair for at least ONE business day to install the power positioning device to their current power wheelchair *(If applicable).*

☐ The applicant meets all Eligibility Criteria as outlined on page 2.

☐ I have reviewed the Equipment Loan Agreement with the Applicant and/or Representative.

Prescriber's Signature _____ Date _____

Prescriber's Printed Name:

Please attach a signed copy of the MWP Equipment Loan Agreement Form