Manitoba
www.manitoba.ca/fs/dhsu

WHEELCHAIR SEATING COMPONENT REQUEST AND JUSTIFICATION FORM

1/4 April 2017

RESET FORM

This request is in support of an individual enrolled in the following program(s):

☐ Employment and Income Assistance ☐ Manitoba Supports for Persons with Disabilities

☐ Children's disABILITY Services ☐ Community Living disABILITY Services

Family Services is authorized to collect personal information and personal health information under section 36(1)(b) of The Freedom of Information and Protection of Privacy Act ("FIPPA") and section 13(1) of The Personal Health Information Act ("PHIA") respectively, as the information is directly related to and necessary for the purposes of administering eligible supports provided by the programs identified at the top of this document and facilitating the procurement and delivery of medical supplies and equipment. We have limited the information we are collecting about you to the minimum amount necessary for these purposes. Your information is protected by the protection of privacy provisions of FIPPA and PHIA. We cannot use or disclose it for any other purpose, unless you consent or we are authorized or required to do so by FIPPA and PHIA. If you have any questions about your information, please contact the FIPPA Coordinator at 204-945-2013 or 2nd floor- 114 Garry St, Winnipeg MB R3C 4V4.

PROGRAM OBJECTIVE: To provide basic, cost effective medical equipment and devices to meet a medically essential need.

- **This form must be completed by an Occupational Therapist (OT) or Physiotherapist (PT) when requesting wheelchair seating components.**
- **If request is for additional seating components for a previous application that was submitted within the last 6 months, complete only sections #1,2,8, and 9. Provide date original request was submitted _____.**
- **Incomplete forms will be returned.**
- **Forward completed request and quote from selected authorized vendor by fax to 204-945-1436, by e-mail to disandhealthsupports@gov.mb.ca, or by mail to Disability and Health Supports Unit – Provincial Services / 100-114 Garry Street, Winnipeg MB R3C 4V4.**
- **Telephone inquiries, call 204-945-4393 or toll free 1-877-587-6224.**
- **Contact Materials Distribution Agency (MDA) at 204-945-8611 or 1-877-632-7867 or by e-mail at e-order@gov.mb.ca directly for repairs or replacement of same exact part/component.**

SECTION #1: CLIENT INFORMATION

CLIENT SURNAME	GIVEN NAME	MIDDLE INITIAL	BIRTHDATE (DD MM YY)	
HOME ADDRESS:	**TOWN/CITY**	**POSTAL CODE**	**TELEPHONE/CONTACT NUMBER**	
MAILING ADDRESS (if different from above)	**TOWN/CITY**	**POSTAL CODE**	**GENDER:** ☐ M ☐ F	**PHIN:**
PARENT/GUARDIAN / AGENCY (if applicable)			**CASE NUMBER** (if applicable)	

HEIGHT	WEIGHT	ARE ANY OF THESE BENEFITS COVERED UNDER OTHER PUBLIC OR PRIVATE HEALTH CARE PLAN ? ☐ YES ☐ NO IF YES, SPECIFY: ☐ FNIHB ☐ MPI ☐ WCB ☐ Blue Cross ☐ Spinal Cord Injury Program ☐ Other

IS THIS CLIENT PENDING HOSPITAL DISCHARGE? ☐ YES ☐ NO	DISCHARGE DATE	DATE OF REQUEST

SECTION #2: PRESCRIBER (OCCUPATIONAL THERAPIST/PHYSIOTHERAPIST LICENSED TO PRACTICE IN MANITOBA)

SURNAME	GIVEN NAME	DESIGNATION ☐ OT ☐ PT	ORGANIZATION

ADDRESS	TOWN/CITY	POSTAL CODE	TELEPHONE NUMBER

FAX NUMBER	E-MAIL ADDRESS	SIGNATURE

Client's Name _____

SECTION #3: DIAGNOSIS / PRESENTING MEDICAL CONDITION

SECTION #4: MOBILITY BASE

IF THE CLIENT HAS A CURRENT MOBILITY BASE, DESCRIBE THE MOBILITY BASE BELOW:			
OWNER	TYPE, MODEL, SPECIFICATIONS, DESCRIPTION		
☐ SMD ☐ EIA or MS ☐ CLIENT ☐ OTHER	☐ STROLLER ☐ MANUAL ☐ MANUAL TILT ☐ MANUAL RECLINE	☐ POWER ☐ POWER TILT ☐ POWER RECLINE ☐ POWER ELR	
AGE OF MOBILITY BASE IF KNOWN:	WILL CURRENT MOBILITY BASE NEED TO BE REPLACED? ☐ YES ☐ NO IF NO, GO TO SECTION #5		
IF REPLACING CURRENT MOBILITY BASE, DESCRIBE THE NEW MOBILITY BASE BELOW			
TYPE. MODEL, SPECIFICATIONS, DESCRIPTION			
☐ STROLLER ☐ MANUAL ☐ MANUAL TILT ☐ MANUAL RECLINE	☐ POWER ☐ POWER TILT ☐ POWER RECLINE ☐ POWER ELR		
CLIENT DOES NOT HAVE A CURRENT MOBILITY BASE, BUT ☐ WILL SUBMIT SMD APPLICATION ☐ SMD APPLICATION WAS SUBMITTED ☐ OTHER			
IF THE CLIENT IS GETTING HIS/HER FIRST MOBILITY BASE, DESCRIBE THE NEW MOBILITY BASE BELOW:			
TYPE. MODEL, SPECIFICATIONS, DESCRIPTION			
☐ STROLLER ☐ MANUAL ☐ MANUAL TILT ☐ MANUAL RECLINE	☐ POWER ☐ POWER TILT ☐ POWER RECLINE ☐ POWER ELR		

SECTION #5: SEATING

IF THE CLIENT DOES NOT HAVE CURRENT SEATING, PROCEED TO SECTION #6

IF THE CLIENT HAS CURRENT SEATING, DESCRIBE THE CURRENT SEATING COMPONENTS BELOW

SEATING COMPONENTS	NEED TO CHANGE	IF YES, PROVIDE REASON (S) FOR NEED TO CHANGE	AGE OF COMPONENT IF KNOWN
	☐ YES ☐ NO		
	☐ YES ☐ NO		
	☐ YES ☐ NO		
	☐ YES ☐ NO		
	☐ YES ☐ NO		

Client's Name _____ **3/4 April 2017**

SECTION #6: ASSESSMENT FINDINGS

FUNCTIONAL MOBILITY AND TRANSFERS

SITTING BALANCE	☐ INDEPENDENT	☐ ASSISTED	☐ DEPENDENT	
DYNAMIC WEIGHT SHIFTING	☐ INDEPENDENT	☐ ASSISTED	☐ DEPENDENT	
TRANSFERS	☐ INDEPENDENT	☐ ASSISTED	☐ DEPENDENT	
POWER CHAIR DRIVING	☐ INDEPENDENT	☐ ASSISTED	☐ DEPENDENT	
MANUAL CHAIR PROPULSION	☐ INDEPENDENT	☐ ASSISTED	☐ DEPENDENT	
AMBULATION	☐ INDEPENDENT	☐ ASSISTED	☐ DEPENDENT	☐ DOES NOT WALK

DESCRIBE POSITIONING TENDENCIES AND RANGE OF MOTION FOR SEATING, ETC

PELVIS:

HIPS:

SPINE:

HEAD /NECK:

KNEES:

ANKLES / FEET:

SKIN INTEGRITY

☐ **SKIN IS INTACT WITH NO HISTORY OF PRESSURE SORE**

☐ **SKIN IS INTACT WITH HISTORY OF PRESSURE SORE**

☐ **HAS A CURRENT STAGE _____ PRESSURE SORE ON THE** _____

☐ **THIS IS A NEW PRESSURE SORE** ☐ **THERE IS HISTORY OF PRESSURE SORE ON THIS SITE**

☐ **CONTINENT** ☐ **INCONTINENT OF :** ☐ **BLADDER** ☐ **BOWEL** ☐ **RISK OF SKIN BREAKDOWN :** ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH**

ADDITIONAL COMMENTS IF ANY:

SITTING TOLERANCE AND COMFORT

SITTING TOLERANCE ☐ **LOW** ☐ **MODERATE** ☐ **HIGH**

COMFORT LEVEL ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

High Discomfort — High Comfort

ADDITIONAL COMMENTS IF ANY:

Client's Name _____ 4/4 April 2017

SECTION #7: TARGETED OUTCOMES

SECTION #8: PRODUCT TRIAL

PRODUCTS TRIALED	WAS TRIAL SUCCESSFUL?	IF YES, DESCRIBE OUTCOME
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
IF EQUIPMENT WAS NOT TRIALED, PROVIDE REASON:		
SELECTED AUTHORIZED VENDOR (S) WHO PROVIDED THE TRIAL EQUIPMENT:		

SECTION #9: FINAL PRESCRIPTION

QTY	PRODUCT –MAKE, MODEL, SIZE, ETC	☐ CUSTOM MODIFICATION REQUIRED Must provide rationale to support need for custom modification.
DELIVERY INSTRUCTIONS		PRESCRIBER TO BE PRESENT AT INSTALLATION ☐ YES ☐ NO

PRINT FORM

SUBMIT FORM