

**WHEELCHAIR AND SEATING
REQUISITION FORM
FAMILY & COMMUNITY SERVICES**

SECTION "A" CLIENT INFORMATION

NAME: _____ DATE OF BIRTH: ____/____/____
Day Month Year

ADDRESS: _____ TELEPHONE: _____

FCS I.D. #: _____

PHYSICIAN: _____ MEDICARE #: _____

Is there other insurance coverage available? Yes No If yes, company and policy # _____

SECTION "B" EQUIPMENT INFORMATION

Current Equipment _____

Date obtained _____ Paid by? _____ Why is it no longer appropriate?

Can it be recycled? Y N

Wheelchair/ Seating Requested _____

SECTION "C" MEDICAL INFORMATION

Diagnosis/ medical condition _____

Prognosis (if available) _____

SECTION "D" CLIENT ASSESSMENT

Physical assessment: Weight _____

	Within Normal Limitations	Some Limitations*	Non-Functional*	Comments * if this space is insufficient, please use additional space on page 4
Head/ Neck				
Trunk				
Pelvis				
Upper Extremities				
Lower Extremities				

Sensation				
Skin Integrity				
Tone				

Is the client's condition stable? Y N. If no, please explain _____

Functional assessment:

How does the client currently mobilize inside their home? _____ outside the home? _____

How would this change with the prescribed wheelchair? _____

Is the client able to transfer independently? Y N. If not, please explain what assistance is required. _____

Equipment Trial: **Assessment equipment was provided by:** _____

The prescribed equipment assisted the client with:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Eating, self feeding | <input type="checkbox"/> Safety | <input type="checkbox"/> Mobility | <input type="checkbox"/> Maintenance of range of motion |
| <input type="checkbox"/> Comfort | <input type="checkbox"/> Pain control | <input type="checkbox"/> Safety of caregivers | <input type="checkbox"/> Preventions of contractures |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Joint protection | <input type="checkbox"/> Skin integrity | <input type="checkbox"/> Independence with ADL's |
| <input type="checkbox"/> Elimination of restraints | <input type="checkbox"/> Participation in functional activities | <input type="checkbox"/> Improved sitting tolerance | |
| <input type="checkbox"/> Other (please explain) _____ | | | |

Why was the prescribed make and model chosen? Which features are essential and why? _____

Are the client and/ or caregiver able to operate this equipment properly and safely? Y N. If no, please elaborate. _____

Does the client have the physical and cognitive skills necessary to use this equipment safely and independently? Y N. If no, please elaborate. _____

Was the client assessed with the recommended equipment in their home environment? Y N. If not, please describe what measures have been taken to ensure that the client will be able to use it in his/her home? _____

I would categorize this client's need for mobility as: Basic Intermediate
(Please choose one, based on the Mobility Systems Prescription Grid) Complex Specialty

Environmental factors:

Does the client live alone? Y N If not, is he/ she ever left alone? Y N If so, for what periods of time daily? _____ Does the client have attendants/ caregivers/ homemakers? Y N. If so, how many hours per day? ____ hrs. To assist with what tasks? _____

Are all necessary areas of the client's home accessible to this wheelchair? Y N. If not, please explain which ones are not and why _____

Projected Usage:

Will this wheelchair meet all the client's mobility needs? Y N If not, what other mobility equipment is used on a regular basis? _____

How frequently and for what purposes? _____

How long will the client require this wheelchair? 3 mos 6 mos 1 yr 5 yrs indefinitely

Client will use this wheelchair: _____ hours/day **OR** _____ hours/week

Please check all that apply: in their home in school for medical appointments
 for social activities outside the home for work/ vocation
 other (specify) _____

Does this wheelchair have the durability and adjustability to meet the projected future needs of this client? Y N.
Please elaborate. _____

Will this wheelchair need to be transported? Y N If so, by what means? _____

**** Seniors only**** Is this equipment available from the Red Cross Seniors Rehabilitation Program? Y N
Date checked _____

SECTION "E" ATTACHMENTS

- Quotation (s)
- Doctor's prescription (power wheelchair only)
- Equipment specifications / order form
- Other _____

**NOTES: 1) TO AVOID DELAYS, PLEASE ENSURE THAT THIS FORM IS COMPLETED IN FULL
2) ADDITIONAL INFORMATION MAY BE NECESSARY IN SOME SITUATIONS**

SECTION "G" CONSENT (HEALTH SERVICES COPY)

RE: _____ **EQUIPMENT:** _____
(Client name)

I _____ agree with the recommendations of the undersigned medical professional and I give consent to him/ her to release the enclosed information on my behalf to the Department of Family and Community Services, Easter Seals New Brunswick and any other agency who may be able to assist in the provision of the prescribed equipment.

I understand and accept the following terms of this loan:

- 1) The equipment provided may be new or recycled
- 2) I agree to care for it as I have been instructed and to have all repairs and maintenance carried out by a certified technician or qualified medical professional *
- 3) I agree to operate this equipment safely and not to abuse or misuse it in any way.
- 4) Once the equipment is no longer required, I will return it to Easter Seals NB for recycling.*

* Repairs, maintenance and shipping for this item are provided at no cost to you, if you have a valid Health Card with Family and Community Services and the terms of this loan agreement are upheld.

I have been provided with a copy of this agreement for my future reference.

Signature of Client/ / _____ Date _____
Designate/ Legal Guardian/ Sponsor
or Director of Nursing

Witness: _____ Date _____

Please forward entire package to: Health Services Claims
PO Box 5500, Fredericton, NB E3B 5G4
Fax: (506) 453-3960

REFERRING MEDICAL PROFESSIONAL:

Name: _____ Title: _____
(please print)

Telephone: _____ Facsimile: _____

Mail: _____ E-mail: _____

Signature: _____

Date submitted: to Health Services _____ to Easter Seals NB _____

SECTION "H" CONSENT (TO BE GIVEN TO THE CLIENT)

RE: _____
(Client name)

EQUIPMENT: _____

I _____ agree with the recommendations of the undersigned therapist and I give consent to him/ her to release the enclosed information on my behalf to the Department of Family and Community Services, Easter Seals New Brunswick and any other agency who may be able to assist in the provision of the prescribed equipment.

I understand and accept the following terms of this loan:

- 1) The equipment provided may be new or recycled
- 2) I agree to care for it as I have been instructed and to have all repairs and maintenance carried out by a certified technician or occupational therapist *
- 3) I agree to operate this equipment safely and not to abuse or misuse it in any way.
- 4) Once the equipment is no longer required, I will return it to Easter Seals NB for recycling.* (for more information, please contact them at 1-888-280-8155)

* Repairs, maintenance and shipping for this item are provided at no cost to you, if you have a valid Health Card with Family and Community Services and the terms of this loan agreement are upheld.

I have been provided with a copy of this agreement for my future reference.

Signature of Client/ _____ Date _____
Designate/ Legal Guardian/ Sponsor
or Director of Nursing

Witness: _____ Date _____

