Adult Power Mobility

First complete the I CAN Centre Request for Services Form and this secondary form. This information is needed to assess your need for power mobility. The information will be used to help the I CAN Centre to prepare for the assessment.

*Additional information about the assessment process is available in the **Power Mobility Information Sheet.** Please read this prior to your first appointment.*

Name: Glenrose ID

Occupational/Physical Therapist Name Contact Information:

Medical Diagnosis:

1. Are you able to indicate that you want a power wheelchair?

2. Why do you want a power wheelchair?

COMMUNICATION:

3. How do you communicate?

☐ Verbal ☐ Gestures

☐ Communication device

4. How do you indicate "yes" _____

5. How do you indicate "no" _____

6. Are you able to answer questions consistently? Yes / No

7. Can you follow verbal directions?

8. How long can you focus on an activity?

☐ Less than 15 minutes ☐ ☐ 15 minutes or more

TRAINING

9. Is there someone who is available for a minimum of 30 minutes daily to help teach you the pre-skills and skills required to drive? Yes / No

10. Name of person:

11. Where will you practice?

12. Are there any conditions that **may** make safe driving a challenge (such as poor vision, uncontrolled movements, learning style, behaviors, difficulty moving, uncontrolled seizures)? Please describe:

13. Can you move around independently now? Yes No

Please describe:

14. Describe any method of mobility used.

At home

On outings:

a) Indoors _____
b) Outside

15. How far can you push your manual wheelchair?

16. Can you keep up with peers?

At home, where will you use a power wheelchair?

☐ Inside ☐ Outside

Describe the terrain:

Is the home wheelchair accessible? Yes No

17. In the community, where will you use a power wheelchair?

18. Are these areas wheelchair accessible? Yes / No

19. Will you always be accompanied by a caregiver when driving? Yes No

20. How often would you use a power wheelchair?

_____ hours/day _____days/week

21. When would you use a manual wheelchair instead of a power wheelchair?

DEVICE HISTORY

22. Have you used a joystick or switches with any other device (such as a computer or communication device)? Describe

23. Have you ever been assessed previously or tried a power wheelchair? Yes / No

If yes, when? _____

What method did you use to drive?

☐ Joystick?

☐ Adaptations to joystick?

☐ Other?

What was the result?

24. What movement can you control the best? Describe:

25. How do you think you could best operate the chair? (such, by hand, head, foot.)?

26. If necessary for success, are you willing to try driving with parts of the body other than the hand?

27. How will a power wheelchair be transported?

☐ Private van/truck ☐ ☐ With lift ☐ ☐ With ramp

☐ Will get van adapted if necessary Height of van doorways _____

☐ Public transportation (handibus, low level bus)

☐ Other _____

28. What funding do you have available?

☐ Alberta Aids to Daily Living - Cost Share Yes No

☐ Health Canada (Band Name and No). _____

☐ Motor Vehicle Accident Claim No _____

If AADL or Health Canada does not fund the power wheelchair, or if you needs components that are not covered by the above agencies, are there alternate sources of funding?

☐ Private medical insurance ☐ Other

☐ Charitable organization

SEATING INFORMATION

29. Do you have a manual wheelchair? Yes / No /

Brand name Seat width Seat depth

Special features:

☐ recline ☐ ☐ tilt-in-space ☐ ☐ other

Are you getting a new manual wheelchair?

Brand name Seat width Seat depth

Special features:

☐ recline
☐ tilt-in-space
☐ other

PLEASE ANSWER IF YOU HAVE AN EXISTING POWER WHEELCHAIR

30. Do you have a power wheelchair? Yes /No / On order

If yes, complete the following:

Brand name: Serial No: Seat width:

Seat depth: Age of present chair:

Name of purchaser

☐ AADL ☐ ☐ Insurance

☐ Charitable organization. Name _____

31. For AADL chairs only:

Has AADL written off this power chair? Yes / No

Name of vendor who inspected chair:

Method of driving (type of joystick/ switches and location)

Reason for this request for a review / new wheelchair?

Seating system for existing Power Wheelchair:

Can the seating system be easily and quickly removed from the wheelchair and transferred to an assessment wheelchair? Yes / No

Is the back connected to the seat base by a bracket when it is removed? Yes / No

What seat do you presently have? Please describe.

a. Base/Cushion

b. Back

c. Laterals Yes / No / Swingaway

d. Headrest-

e. Footrest

f. Straps

g. Other

h. Tray:

☐ Clear ☐ Wooden ☐ No tray

What do you use your tray for?

33. Do you have a speech device or computer mounted on the tray? Yes / No

34. Will you be getting a new seating system in the near future? Yes / No

35. Do you have a seating appointment scheduled? If so, provide date: _____

36. What is the reason for the seating appointment?

37. How do you transfer in/out of the chair?

☐ Standing ☐ 2 Person

☐ 1 person lift ☐ Mechanical lift

SPECIAL REQUIREMENTS FOR A POWER WHEELCHAIR

38. Do you require a tilt on your power wheelchair? Yes / No

If yes, why?

39. Do you require a recline on your power wheelchair? Yes / No

If yes, why?

40. Are you ventilator dependent? Yes / No

If yes, length of time you can be off ventilator

Describe what respiratory equipment is needed on the wheelchair

41. Is there any other equipment that needs to be carried on the power wheelchair (such as a communication device)?

Person(s) completing this referral form:

Person's/Guardian's Signature

Occupational/Physical Therapist Signature

Date Completed:

Please return to:
I CAN Centre for Assistive Technology
Glenrose Rehabilitation Hospital
10230-111 Avenue, Edmonton, Alberta, T5G 0B7
780-735-6070; Fax: 780-735-6072
www.albertahealthservices.ca/icancentre.asp