



MEDICAL REPORT FORM
for application for funding for Power Mobility Aid

To be completed by family physician who is familiar with patient's condition

Please print

Patient Name: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Other conditions pertaining to need for power mobility: \_\_\_\_\_

What is the patient's primary method of mobility?

Unassisted [ ] Cane/crutches [ ] Walker [ ] Manual Wheelchair [ ] Power Mobility [ ]

What difficulty is the patient having with this method? \_\_\_\_\_

Does patient's physical condition warrant the need for power mobility in order to complete activities of daily living because he/she is unable to walk (with aides, if necessary) or self-propel manual wheelchair functionally more than 50 metres (150 feet)?

Yes [ ] No [ ]

If yes, which type of power mobility aid would be most suitable to patient's physical condition and intended use?

3 wheeled scooter [ ] 4 wheeled scooter [ ] Power wheelchair [ ]

Please explain: \_\_\_\_\_

Is patient's condition progressive, requiring reassessment of ability to safely use power mobility?

Yes [ ] No [ ]

If yes, please explain and indicate when this should be done and by who: \_\_\_\_\_

Does patient have a visual, cognitive or physical impairment that would risk his/her safety, or that of other people, or the potential to damage property if he/she was using a power mobility aid?

Yes [ ] No [ ]

If yes, please indicate any restrictions that should be placed on use of power mobility: \_\_\_\_\_

Patient is responsible for any costs related to completing this form.

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician Name (please print) \_\_\_\_\_

Phone number \_\_\_\_\_

Please return completed form to:

Easter Seals Alberta OR
1408-10025 106 Street
Edmonton AB T5J 1G4 Fax 780-429-1937

Easter Seals Alberta
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Calgary AB T2E 7L4 Fax 403-248-1716