



OCCUPATIONAL/PHYSIOTHERAPIST ASSESSMENT FOR POWER MOBILITY AID

Alberta Easter Seals requires an occupational or physiotherapist assessment be done in conjunction with the client when applying for assistance in obtaining scooters and power wheelchairs. Your assistance in completing this assessment form as completely as possible is greatly appreciated.

Based on the client's needs, lifestyle and accommodation, and **FOLLOWING A TRIAL PERIOD WITH THE EQUIPMENT IN THE HOME ENVIRONMENT**, please include your recommendation of the equipment that will best meet the client's basic needs for the least cost. If "top of the line" equipment is recommended, please provide specific reasons and rationale to support this. Due to numerous requests and the ongoing shortage of available funding, consideration must be given to the fact that it takes much longer to raise a larger sum of money resulting in an extended waiting period for the client.

In determining eligibility, the Alberta Easter Seals gives priority to people needing power mobility in order for them to complete their activities of daily living (shopping, banking, getting to appointments, household management) as opposed to wanting it for socialization or recreational purposes. We view a power mobility aid as a replacement for walking or functionally propelling a manual wheelchair rather than replacement of a vehicle for longer distances.

The information collected on this application form is for the purposes of determining eligibility for assistance. The information will be held in strict confidence and used only for the purpose it was intended.

Please return form to:

Red Deer and north:

Alberta Easter Seals
1408-10025 106 St.
Edmonton AB T5J 1G4

Phone (780) 429-0137
Fax (780) 429-1937
dawn@easterseals.ab.ca

south of Red Deer:

Alberta Easter Seals
103-811 Manning Road NE
Calgary AB T2E 7L4

Phone (403) 235-5662
Fax (403) 248-1716
theresa@easterseals.ab.ca

Visit our website at www.easterseals.ab.ca



OCCUPATIONAL OR PHYSIOTHERAPIST ASSESSMENT FORM FOR POWER MOBILITY

Applicant Name: _____

Address: _____ Phone number:(____) _____

Primary Diagnosis: _____

Other relevant conditions: _____

Prognosis: _____

Height: _____ Weight: _____

DESCRIPTION OF DISABILITY: (strength, balance, endurance, hand function, level of independence, transfers, as relevant to equipment requested)

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? _____

Which power mobility aids (make, model) has applicant tried during assessment?

Specific make and model recommended and why? _____

How often and where would applicant use mobility device? _____

Do you see this equipment as being a necessity for applicant's activities of daily living or more of a quality of life/recreational vehicle? Please explain:

Please give rationale behind choice of 3 or 4 wheeled scooter or power wheelchair as most suitable:

How long do you think the applicant would be able to use this piece of equipment? _____

Type of controls: right left centre head other_____

Seat size:_____ Seat type:_____

- seating tolerance? _____

- any disabilities that would impact type of seat or locking mechanism required? _____

- has referral been made to seating clinic, if necessary? _____

Adaptations and/or accessories required (i.e. cane holder, suspension, oxygen tank holder, delta tiller)?

Is client able to do own maintenance (battery charging, light maintenance, cleaning)? _____

If assistance required, is it available and by who? _____

NOTE: THE REQUESTED EQUIPMENT MUST BE TRIALED ON TRANSPORTATION SYSTEM

Transportation of equipment will be by:

Own vehicle - Year/Make/model: _____

Will applicant be driving the vehicle? _____

List adaptations required _____

Specialized parallel transit

Low Floor Bus

None required

Are there any size restrictions on mobility device due to transportation? If so, what are they:

ACCESSIBILITY:

HOME:

Type of accommodation: _____

Is home wheelchair/scooter accessible? _____

Are there any ramps/lifts? _____ where? _____

Where will equipment be stored/charged? _____

OTHER:

Are the other environments (work, school, community, recreation) that applicant is involved in accessible? Please comment and give examples:

SAFETY:

Does applicant 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?

If training is required to safely use power mobility, who will do it? _____

Any problems/difficulties encountered during trial? _____

Therapist's impressions and additional comments, including urgency of request and suitability:

If this request is for a power wheelchair, has the client been denied by Alberta Aids to Daily Living? Why? Has the decision been appealed? (Please enclose a copy of the letter(s) of denial)

Name of therapist: _____ Phone: () _____
(Please print)

Address: _____ Fax: () _____

E-mail: _____

Signature: _____ Date: _____