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
404-10525-170 Street
Edmonton AB T5P 4W2 Fax 780-429-1937

OR

Easter Seals Alberta
103-811 Manning Road NE
Calgary AB T2E 7L4 Fax 403-248-1716