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