Easter Seals Alberta

EMPOWERING
people with disabilities

OCCUPATIONAL OR PHYSIOTHERAPISTASSESSMENT
FOR POWER MOBILITY AID

Easter Seals Alberta 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.

FOLLOWING A TRIAL PERIOD WITH THE EQUIPMENT IN THE HOME ENVIRONMENT AND NEIGHBOURHOOD, please include your recommendation of the equipment that will best meet the client's basic needs for the least cost (please contact our office to ask about specific equipment for trials). Please be aware: if a suitable piece of equipment is available in our loan pool, the client may not receive the exact item as requested.

In determining eligibility, the Easter Seals Alberta 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:

Easter Seals Alberta
Mayfield Business Centre
404, 10525 170 Street
Edmonton AB T5P 4W2

Phone (780) 429-0137 ext. 303
Fax (780) 429-1937
debbie@easterseals.ab.ca

south of Red Deer:

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

Phone (403) 235-5662 ext. 214
Fax (403) 248-1716
theresa@easterseals.ab.ca

For more information about Easter Seals Alberta and our programs, and to download copies of our forms, visit our website at **www.easterseals.ab.ca**

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EMPOWERING *people with disabilities*

OCCUPATIONAL OR PHYSIOTHERAPIST
ASSESSMENT FOR POWER MOBILITY AID

Applicant Name: _____ Phone number: (____)_____

Address:_____Town/City:_____Postal Code:_____

Primary Medical Diagnosis:_____

Other relevant medical / physical 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?

Where and for what time period was (were) the power mobility aid(s) trialed?

Specific make and model recommended and why?

How **often**, where and for what activities would applicant use mobility device?

Are there any space limitations/challenges in their current living environment?

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 either a power scooter versus a power wheelchair.

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?_____

Physically 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)? No

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

NOTE: THE REQUESTED EQUIPMENT MUST BE TRIALED ON TRANSPORTATION SYSTEM IF POSSIBLE

Transportation of equipment will be by:

☐ Own vehicle - Year/Make/model:_____

☐ Will applicant be driving the vehicle?

List adaptations required_____

☐ Specialized parallel transit (eg-DATS, SCATS)

☐ 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? _____

If renter, does applicant have landlord approval for storing mobility aid in their suite? ☐ _____

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: _____

Any personal information that Easter Seals Alberta may collect is collected in compliance with section 33 (c) of the Freedom of Information and Protection of Privacy (FOIP) Act. The information collected is limited to what is necessary for determination of eligibility for benefits and programs. This information and all associated records and files shall remain under control of Alberta Human Services ministry and will be provided to them upon their request. All reasonable efforts shall be taken against such risks as unauthorized access, collection, use, disclosure, disposal and disaster. For any questions or concerns about the collection, use and disclosure of personal information, contact Easter Seals Alberta Caseworker.