



Alberta

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