

SENIOR'S COMMUNITY WHEELCHAIR LOAN PROGRAM



Policy: Senior's Community Wheelchair Loan Program

Originating Branch: Continuing Care

Original Approval Date: June 13, 2013 **Effective Date:** September 1, 2013

Approved By: *Original signed by Kevin McNamara*

Kevin McNamara, Deputy Minister Health and Wellness

Version # 02

Section 1: Policy Statement

The Seniors Community Wheelchair Loan Program provides and recycles seating and mobility system to eligible residents of Nova Scotia thereby supporting them in remaining in their homes and participating in their communities. The Seniors Community Wheelchair Loan Program is administered and delivered by the District Health Authorities (DHA) in collaboration with approved vendor(s) and funded by the Nova Scotia Department of Health and Wellness (DHW). There are no fees charged to individuals who access this service. Funding is for a manual or powered wheelchair, and related seating components, which meet minimum requirements, as assessed by an authorized health care provider and includes maintenance costs and general repairs.

The Seniors Community Wheelchair Loan Program is a recycling program and if it is determined that a recycled wheelchair and/or related seating components are available and can be adapted to suit the client's needs, that recycled wheelchair and/or related seating component will be provided by the program. Access to the Seniors Community Wheelchair Loan Program is through the District Health Authority's continuing care single entry access system.

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Section 2: Definitions

For the purposes of this policy the following definitions will apply:

Applicant: A resident of Nova Scotia who applies for access to the Seniors Community Wheelchair Loan Program through the District Health Authority continuing care program.

Client: An applicant who meets the program criteria and is approved by the District Health Authority continuing care program to receive seating and mobility equipment through the Seniors Community Wheelchair Loan Program.

Authorized Representative: An individual that the approved client consents to be involved while accessing the Seniors Community Wheelchair Loan Program. This may be but is not limited to a substitute decision maker or a power of attorney.

Care Coordinator or delegate: An employee of the District Health Authority who is responsible for the determination of eligibility for the Seniors Community Wheelchair Loan Program.

Authorized Health Care Provider: An occupational therapist (OT) or physiotherapist (PT) who is skilled in the provision of appropriate wheelchairs. The OT or PT must be registered to practice in Nova Scotia.

Vendor(s): An organization / company that has been authorized by the Department of Health and Wellness to provide, service, track and deliver appropriate wheelchairs under the Nova Scotia Seniors Community Wheelchair Loan Program.

Wheelchair (Seating and Mobility System): A prescribed wheelchair that consists of seating components and a mobility base. Examples of seating components are cushions and head supports. An example of a mobility base is a manual wheelchair.

Appropriate Wheelchair (Seating and Mobility System): Is a wheelchair that:

- Meets the user's needs and environmental conditions;
- Provides proper fit and postural support and is safe and durable;
- Is available in Canada;
- Can be obtained and maintained and services sustained at the most economical and affordable price.

Seating Components: The seating components allow the wheelchair user to function in the seating and mobility system in a safe and sustained manner. Generally the seating components are the equipment between the wheelchair user and the mobility base.

a) **Positioning Components:** are the parts of the system that strive to balance function, postural support, comfort and skin health.

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- **Static:** are fixed positioning components such as cushions, headrests and back supports.
- **Dynamic:** are movable positioning components such as tilt, recline and leg elevation. They may be either manual or powered.

b) Other Essential Components: include equipment such as ventilator trays

Mobility Base – Wheelchair: The mobility base allows the wheelchair user to move throughout his or her environment. The appropriate method of mobility may vary greatly between individuals. Some examples include using one arm and one leg, small head movements or both arms. Generally the mobility base is the equipment between the ground and the seating components.

a) Manual Wheelchairs are propelled by the user or pushed by another person.

b) Power Wheelchairs are propelled by electric motors and may be operated by the user or another person.

Continuing Care Single Entry Access System: The centralized intake 1-800-225-7225 for residents of Nova Scotia to access programs and services available through DHA Continuing Care.

Home Care Income Category: A determination of the applicant's income status which is based on net income and family size of the individual and is calculated using Section 14.2 Home Care Fee Determination Process of the Department of Health and Wellness Home Care Policy Manual.

Definitions based on World Health Organization (WHO). Wheelchair Service Training Package: Basic Level. Geneva, Switzerland: World Health Organization: 2012.

Section 3: Roles and Responsibilities

3.1 Role of the Nova Scotia Department of Health and Wellness

The Department of Health and Wellness is responsible to establish provincial program policy for the delivery of a Seniors Community Wheelchair Loan Program.

The Department of Health and Wellness is responsible to develop, in collaboration with the DHAs, accountability measures, performance measurement and reporting requirements that vendor(s) and District Health Authorities are required to meet.

The Department of Health and Wellness is responsible to administer the allocation of available financial resources for the provision of Seniors Community Wheelchair Loan Program and fund vendor(s) through a Service Agreement.

The Department of Health and Wellness authorizes approved vendor(s) to provide service to the client through a service agreement.

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The Department of Health and Wellness shall notify DHA Continuing Care staff and any changes to authorized vendor(s).

The Department of Health and Wellness is responsible for auditing the Seniors Community Wheelchair Loan Program for compliance with provincial program policy and standards. This audit shall include District Health Authorities and authorized vendor(s).

3.2: Role of the District Health Authority

Each District Health Authority (DHA) is required to provide access to a Seniors Community Wheelchair Loan Program for eligible residents of its district through the Continuing Care Single Entry Access system in accordance with this policy.

Each District Health Authority is required to assess an applicant's eligibility to access the Seniors Community Wheelchair Loan Program and to make an approval decision on the authorization of the covered equipment, as appropriate.

Each District Health Authority care coordinator or delegate and authorized health care provider is responsible to explain the Seniors Community Wheelchair Loan Program policies and procedures to clients, or authorized representative.

Each District Health Authority will ensure consistent roles and responsibilities for the care coordinator or delegate and authorized health care provider with respect to providing the prescribed wheelchair recommendations and appropriate authorization, in collaboration with the vendor(s).

Each District Health Authority is responsible to follow up with clients, or authorized representative, to ensure that the Seniors Community Wheelchair Loan Program provides equipment, including delivery and set up in the client's home along with appropriate education and training in the use of the equipment.

Each District Health Authority is responsible to manage the relationship with the vendor(s) of the Seniors Community Wheelchair Loan Program in an efficient and cost effective manner.

Each District Health Authority is responsible for developing a plan for potential waitlist situations.

Each District Health Authority is responsible to maintain records on all clients in receipt of the Community Wheelchair Loan Program in compliance with Section 4.0.

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3.3: Role of Approved Vendor(s)

The vendor(s) is required to comply with the Department of Health and Wellness (DHW), Seniors Community Wheelchair Loan Program Policy and any financial, reporting and evaluation requirements per their Service Agreement.

The vendor(s) is responsible to ensure that the Seniors Community Wheelchair Loan Program includes provision of the covered equipment identified in the provincial policy.

The vendor(s) is responsible to provide wheelchairs, and related services, for inclusion in their inventory in accordance with the Seniors Community Wheelchair Loan Program Agreement between the vendor(s) and Department of Health and Wellness.

The vendor(s) is responsible to maintain an updated inventory of available equipment for use by clients of the Seniors Community Wheelchair Loan Program which shall be accessible to the District Health Authority.

The vendor(s) is required to ensure that all wheelchairs delivered are in good working order and is responsible to recycle them in whole or in part wherever possible and maintain and repair recycled equipment before posting in inventory and/or reissuing to clients.

The vendor(s) is required to participate in the mock-up trial of the wheelchair as part of the initial assessment.

The vendor(s) is required to provide access to and delivery and set up of wheelchair during normal business hours, Monday to Friday.

The vendor(s) is responsible to respond, where feasible, to urgent requests on an individual basis and deliver and assemble the authorized wheelchair in the clients' home. An urgent request is one in which the health and safety of the client is in immediate risk.

The vendor(s) is responsible to provide clients, or authorized representative, with written instructions/information on the operations of the wheelchair and with contact information for the vendor(s), should concerns arise.

The vendor(s) is required to ensure that Seniors Community Wheelchair Loan Program service consent forms are signed by the client, or authorized representative, as appropriate, and provide a copy to the care coordinator or delegate.

The vendor(s) is responsible to retrieve the wheelchair from the clients' home when no longer required and notify the care coordinator or delegate upon completion.

The vendor(s) is responsible to follow appropriate infection control measures for retrieved equipment before posting equipment to the inventory for access by all DHA's.

The vendor(s) is responsible to honor manufacturer warranties and provide for maintenance and repair costs following any/all standards with respect to inspections.

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Section 4: Program Principles

Respect the individual's rights to dignity, self-determination, and risk by supporting their right to make decisions regarding wheelchair benefits.

Encourage client independence.

Promote client responsibility and accountability associated with health risks, benefits & consequences.

Provide wheelchair benefits as assessed by qualified health professionals to meet clients' basic health needs.

Facilitate reasonable and timely access to wheelchairs.

Demonstrate stewardship and accountability through the delivery of benefit within available resources.

Remain fiscally responsible and look for new, better, and more efficient ways of providing service.

Liaise with related health services and organizations regarding wheelchair benefits, as well as the provision of information to clients regarding health services.

Section 5: Program Eligibility

An individual is considered to be a qualified applicant, for purposes of the Seniors Community Wheelchair Loan Program, when (s)he meets all the following criteria:

- Is a resident of Nova Scotia, with a valid Nova Scotia health card number or is in the process of establishing permanent residence in Nova Scotia and has applied for coverage under Nova Scotia's Health Insurance Plan;
- Is age 65 years or older at the time of application;
- Has annual net income which places the individual in Home Care Client Income Category A, as determined through the current Home Care Fee Determination Process, Section 14.2 of the Department of Health and Wellness Home Care Policy Manual;
- Requires assistance because of a long-term disability, chronic illness, or terminal illness. Long-term and chronic are defined as three months or more;
- Is willing to take responsibility and sign a consent form for safe and proper use of the wheelchair in the home following provision of appropriate training and education related to the wheelchair, or have an authorized representative who is willing to do so;

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- Have been assessed by an authorized health care provider and determined to require the use of a wheelchair on a daily basis in order to perform activities of daily living and to be able to remain in his/her home;
- If client is eligible to receive comparable benefits through another source, such as private insurance and/or privately/publicly funded organizations, they will not be considered for the Seniors Community Wheelchair Loan Program.

Section 6: Application and Approval

Referrals to the Seniors Community Wheelchair Loan Program must be made through Continuing Care's Single Entry Access system.

A care coordinator or delegate will confirm eligibility for access to the Seniors Community Wheelchair Loan Program and refer the file to health care provider point of contact.

An authorized health care provider will determine basic wheelchair needs using a standardized assessment. All assessments must be conducted using the Provincial Seating and Mobility Assessment form (Appendix A).

The authorized health care provider will provide the care coordinator or delegate with a copy of the Provincial Seating and Mobility Assessment Form and a Wheelchair Prescription Form.

The care coordinator or delegate will forward the Wheelchair Prescription Form and a Vendor Authorization Form to the vendor(s).

The client, or authorized representative, is responsible to notify the care coordinator or delegate if (s)he has a change in health status that impacts the appropriateness of the provided wheelchair. The care coordinator or delegate is responsible to initiate a referral for reassessment of the wheelchair by an authorized health care provider.

Wheelchairs are loaned on the basis of specific individual need and cannot be transferred to another person or organization.

Section 7: Covered Equipment

Upon assessment and prescription, the equipment provided through the Seniors Community Wheelchair Loan Program shall consist of the following:

(a) Seating Components:

Positioning Components:

Static: Cushions, back supports, lateral supports, head supports, extremity supports, trays, abductors and adductors, positioning straps and belts.

Dynamic: Tilt, recline, seat and leg elevate; powered or manual.

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(b) Mobility Components:

Manual: Folding and rigid frame chairs

Power: Front, Mid and Rear wheel drive chairs, push-rim activated power assisted wheelchairs, batteries and input components.

Scooters are not included in the Seniors Community Wheelchair Loan Program.

If appropriate recycled seating and mobility equipment is available it will be used first before purchasing new equipment.

The Seniors Community Wheelchair Loan Program will cover only one seating and mobility system at any given time.

Provincial Seating and Mobility Assessment and prescription forms from an authorized healthcare provider are required for replacement of seating and mobility equipment.

Once the client no longer requires the equipment, it remains the property of the vendor(s) and will be returned to and managed by the vendor(s).

Section 8: Maintenance and Repair

The vendor(s) will provide regular preventative maintenance per the manufacturer's guidelines.

Requests for maintenance or repairs above \$1500 (including parts, labour and shipping) will need to be submitted to the DHA Continuing Care for approval. For these repairs the client may contact the care coordinator or delegate to make appropriate arrangements.

Maintenance and repairs may only be performed by approved vendor(s). Trained technicians will repair issued equipment at no cost to the client. Appointments are required for all repairs and bookings are the responsibility of the approved client, or authorized representative.

Once the repair is performed, the vendor(s) must supply the client, or authorized representative, and the District Health Authority with a completed copy of the work order and enter associated data into the inventory of available equipment. The client, or authorized representative, should ensure that the repairs were performed.

Replacement of components other than for maintenance and repair, such as those required due to a change in the clients' functional status, requires completion of the Provincial Seating and Mobility Assessment Form and Wheelchair Prescription Form by an authorized health care provider.

The Seniors Community Wheelchair Loan Program will not authorize requests for maintenance or repair on the following:

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- privately owned wheelchairs;
- when the cost exceeds 50% of the cost of replacement of the manual seating and mobility system;
- when the power seating and mobility system is 5 years old or older and the cost of replacement exceeds \$5000 or;
- when the cost exceeds 60% of the cost of replacement of the power seating and mobility system.

The client, or authorized representative, is responsible to ensure that care of the equipment is provided according to the instructions provided by the vendor(s) and authorized health care provider.

The client, or authorized representative, will be responsible for replacement of lost, stolen, or equipment damaged due to misuse.

Section 9: Discontinuation and Return of Equipment

All equipment must be discretely labeled as property of the vendor(s).

Equipment must be returned to the vendor(s) for recycling when:

- the client no longer needs it; or,
- it has been replaced; or,
- the client's health status changes; or,
- the client moves out of Nova Scotia; or,
- the client becomes otherwise ineligible for the benefit.

It is the responsibility of the client, or authorized representative, to contact the care coordinator or delegate and vendor(s) when the equipment is no longer required.

It is the responsibility of the vendor(s) to collect the wheelchair, follow appropriate infection control measures and sort for recycling or disposal.

When clients move from the community to a long term care facility the wheelchair will remain with the client and the care coordinator or delegate will initiate a referral for reassessment. Wheelchair provision within long term care falls under the Long-term Care Policy Manual – Specialized Equipment Program administered through the Canadian Red Cross.

Section 10: Recycling Equipment

When a seating and mobility system is no longer required, the vendor(s) shall retrieve the equipment within 10 business days of notification by the client, or authorized representative.

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Retrieved equipment will be cleaned using appropriate infection control measures.

Retrieved equipment will be inspected by an authorized technician following industry standards. Any equipment assessed to be appropriate for recycling will be posted in the inventory within 10 business days of retrieval.

Any retrieved equipment assessed to require maintenance and/or repairs shall be completed by the vendor(s) as per Policy 3.2 Maintenance and Repair. Any equipment that requires maintenance and repairs that exceed the outlined authorizations will be discarded.

The vendor(s) would document the maintenance and/or repairs on the specific equipment in the inventory database.

Upon completion of maintenance and repair of retrieved equipment, the vendor(s) would post that equipment in the inventory database.

Section 11: Consents, Confidentiality and Privacy

The District Health Authority and the vendor(s) are responsible to ensure that client records are kept confidential and that the privacy of individual client information is protected.

The District Health Authority and the vendor(s) must make reasonable security arrangements for client records to protect against unauthorized access, collection, use, disclosure, or disposal of personal information.

Information storage methods must permit the ready retrieval and consolidation of client records stored in different formats, for the purpose of secure destruction, in accordance with established record retention schedules.

The District Health Authority is responsible to develop district level policies and procedures that are congruent with provincial SEAScape procedures pertaining to client records.

Once determined to be eligible for the Seniors Community Wheelchair Loan Program, clients may be asked to sign a consent form to agree to share information relative to wheelchair prescription with other care providers. The consent may list specific information that may be shared with the vendor(s) and/or be kept about them in the inventory database.

District Health Authority staff and the vendor(s) shall have authorized access to confidential information for program purposes only (i.e. on a "need to know" basis). The District Health Authority and the vendor(s) must have policies regarding the collection, use, disclosure, and retention of health information with consent or as otherwise specifically authorized in the applicable legislation, e.g.:

Freedom of Information and Protection of Privacy Act (1993, c.5, s.1)

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Health Protection Act (2004, c.4, s.1)

Hospitals Act (R.S., c.208, s.1)

Involuntary Psychiatric Treatment Act (2005, c.42, s.1)

Personal Directives Act (2008, c.8, s.1)

Personal Information International Disclosure Protection Act (2006, c.3, s.1)

Personal Health Information Act

Section 12: Reporting Requirements

District Health Authorities (including care coordinators or delegate and registered occupational therapists and physiotherapist) and vendor(s) are required to comply with all performance measurement and reporting requirements for the Seniors Community Wheelchair Loan Program, as established by the Department of Health and Wellness.

District Health Authorities and authorized vendors are required to comply with the Department of Health and Wellness auditing processes intended to measure compliance with Seniors Community Wheelchair Loan Program policy and standard, as established by the Department of Health and Wellness.

Section 13: Appendices (See the Appendices of this policy manual)

- NS Wheelchair Assessment Form
- NS Wheelchair Equipment Prescription Form

Section 14: Version Control

Version Control:	Replacement of Seniors Community Wheelchair Loan Program Policy Version # 01 June 13, 2013
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Appendix: NS Wheelchair Assessment and Prescription Form



Nova Scotia

Provincial Seating and Mobility Assessment

World Health Organization – Wheelchair Service Provision Steps

- 1. Referral and Appointment 3. Prescription 5. Wheelchair Preparation 7. Training
- 2. Assessment 4. Funding & Ordering 6. Fitting 8. Maintenance & Follow-up

Wheelchair User Name: _____ HCN: _____

Assessment Date (yyyy/mm/dd): _____

- Informed consent for assessment and treatment received from client/caregiver, Photos and
- The release of wheelchair assessment form and prescription to Continuing Care and Vendor
- Health Record Reviewed: YES NO Collateral History Obtained: YES NO

Individual(s) Present for Assessment: (Including Authorized Representative) _____

Referral Source (Including Care Coordinator): _____

Diagnosis/Relevant Medical History: _____

Social/School/Leisure History: _____

Formal Supports: Nursing Home Support (Continuing Care Agency) Private Care Other

Other Supports: _____

Wheelchair Funding Options:

Eligible for Veteran's Affairs Canada (VAC) Funding (K#, VAC Counselor, telephone/fax)

Private Health Insurance Plan (Company, plan/policy #, telephone/fax)

under 19 years old Net total family income under \$90,001 (see website for co-pay matrix)

19-64 years old Net total family income under \$25,001 (see website for co-pay matrix)

Proceed with Nova Scotia Wheelchair Recycling Program Application

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Wheelchair User Name: _____ HCN: _____

Wheelchair Funding Options:	
<input type="checkbox"/> 65 years or older <input type="checkbox"/> Home Care Income Category A Name and Contact Information for Care Coordinator:	
Other Funding Options: <input type="checkbox"/> Health/Diagnostic Association/Society (e.g. ALS, MS, Muscular Dystrophy) <input type="checkbox"/> Other Community Charitable Organizations <input type="checkbox"/> Self Funding	

Home Environment:	
Exterior Entrances	Describe entrance threshold, width, turning radius, automatic-assist doors.
Elevator	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe width, turning radius, button access.
Inside Stairs	Describe #, curves, landings, width, angle, railing, equipment.
Flooring	<input type="checkbox"/> Carpet <input type="checkbox"/> Vinyl/Tile <input type="checkbox"/> Wood <input type="checkbox"/> Laminate
Access to: (Consider door width, turning radius, space for transfers, table/counter heights, etc.)	Kitchen: Bedroom: Living Room: Bathroom (Toilet, sink, shower):

Community Environment:	
Community Destinations	<input type="checkbox"/> Stores <input type="checkbox"/> School <input type="checkbox"/> Medical Centre <input type="checkbox"/> Work <input type="checkbox"/> Recreation <input type="checkbox"/> Other Describe sidewalk, curbs, entrance, etc.
Method of Transport	<input type="checkbox"/> Low Floor Bus <input type="checkbox"/> Accessible Bus <input type="checkbox"/> Accessible Taxi <input type="checkbox"/> Private Vehicle Describe vehicle if an attendant or client is driving, the model, # of doors, where w/c stored, transfer)

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Wheelchair User Name: _____ HCN: _____

Self-Care:	
Communication	<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Augmentative Communication (specify)
Feeding	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent <input type="checkbox"/> Tube Feed
Personal Care (washing, dressing, grooming)	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance <input type="checkbox"/> Dependent (Describe method, frequency, assistance)
Bowel/Bladder	<input type="checkbox"/> Continent Incontinent: <input type="checkbox"/> Bowel <input type="checkbox"/> Bladder <input type="checkbox"/> Indwelling Catheter <input type="checkbox"/> Condom Catheter <input type="checkbox"/> Intermittent Catheter Describe products used, frequency, schedule, method, and assistance (etc.).

Ambulation and Transfers:	
Walking	<input type="checkbox"/> Not at all <input type="checkbox"/> Inside the home <input type="checkbox"/> In the community If walking, describe distance, terrain, equipment used.
Transfers	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance (Describe surfaces, method, equipment, level of assistance, frequency)
Mechanical Lift	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Floor Model <input type="checkbox"/> Ceiling Track <input type="checkbox"/> Free Standing Track <input type="checkbox"/> Other Describe lift model, transfer surfaces, sling, method, level of assistance, frequency. <input type="checkbox"/> Training required

Physical:	
Sensation	Impaired <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Edema	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Skin	History of Open Skin Area(s): Current Open Skin Area(s): Stage of Open Area(s): # Hours/Day Sitting /Lying(describe surfaces):

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Wheelchair User Name: _____ HCN: _____

Skin (cont'd)	Braden Scale Score:
	Weight Shift Method(s) <input type="checkbox"/> Side Leaning <input type="checkbox"/> Forward Leaning <input type="checkbox"/> Push-up lift <input type="checkbox"/> Mechanical Tilt <input type="checkbox"/> Mechanical recline <input type="checkbox"/> Other <input type="checkbox"/> Training required
Tone	Upper Extremity <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> High <input type="checkbox"/> Low Dominance: R / L Lower Extremity <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> High <input type="checkbox"/> Low Other <input type="checkbox"/>
	Pain <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Swallowing	<input type="checkbox"/> Within Normal Limits
Cardio-Respiratory	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Shortness of Breath on Exertion Pulse Oximeter Reading in Wheelchair (if available):
Seizures	<input type="checkbox"/> No History of Seizures <input type="checkbox"/> Seizure History (Describe type, frequency).

Visual, Perceptual, Auditory, Cognitive:	
Vision	<input type="checkbox"/> Functional <input type="checkbox"/> Impaired <input type="checkbox"/> Legally Blind Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> L / R Visual Field Loss
Perception	<input type="checkbox"/> L / R Neglect <input type="checkbox"/> Other perceptual assessments findings:
Hearing	<input type="checkbox"/> Functional <input type="checkbox"/> Impaired Hearing Aids: L / R
Cognition (e.g. judgment, insight, attention, concentration, learning, problem solving, motor planning)	<input type="checkbox"/> No functional cognitive impairment noted <input type="checkbox"/> Cognitive screen completed - tool/score/date: <input type="checkbox"/> Other cognitive assessments findings:

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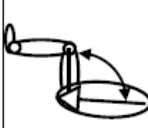
Wheelchair User Name: _____ HCN: _____

Wheelchair Mobility:	
<input type="checkbox"/> Manual	Drive Method: <input type="checkbox"/> Dependent <input type="checkbox"/> Self-Propel Describe model, width, depth, height, cushion, back, arm rests, footrests, positioning aid. Wheelchair Skills (including safety): <input type="checkbox"/> Independent Indoor <input type="checkbox"/> Independent Community <input type="checkbox"/> Independent Advanced <input type="checkbox"/> Training required <input type="checkbox"/> No training required
<input type="checkbox"/> Power	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter Drive Method: <input type="checkbox"/> Dependent <input type="checkbox"/> Independent Describe: model, width, depth, height, cushion, back, arm rests, footrests, positioning aid. Wheelchair Skills (including safety): <input type="checkbox"/> Independent Indoor <input type="checkbox"/> Independent Community <input type="checkbox"/> Independent Advanced <input type="checkbox"/> Training required <input type="checkbox"/> No training required

POSTURE OBSERVED IN CURRENT SEATING SYSTEM			
Planes	SAGITTAL	FRONTAL	TRANSVERSE
Pelvis	Tilt	Obliquity	Rotation
	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral
	<input type="checkbox"/> Anterior	Lower on the:	Forward on the:
	<input type="checkbox"/> Posterior	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R
Hips	FLEXION (Functional)	AD/ABduction	ROTATION
	<input type="checkbox"/> WFL or	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral
	Approximate angles: R ~ _____ ° L ~ _____ °	ABduction ADduction <input type="checkbox"/> L <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> R	Internal External <input type="checkbox"/> L <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> R
Trunk	FLEXION/EXTENSION	SCOLIOSIS	ROTATION
	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral
	<input type="checkbox"/> Lordosis	Convex to the :	Forward to the:
	<input type="checkbox"/> Kyphosis	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R
		<input type="checkbox"/> S- Curve	
Upper Extremities	PRO/RETRACTION	SUBLUXATION	
	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral	
	<input type="checkbox"/> Protraction	Subluxation on the:	
	<input type="checkbox"/> Retraction	<input type="checkbox"/> L <input type="checkbox"/> R	
Other relevant observations (e.g. head/neck postures, foot orientation, etc.)			
<input type="checkbox"/> photo taken			


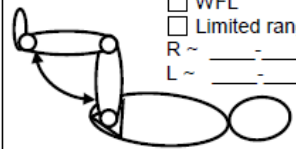
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Wheelchair User Name: _____ HCN: _____

POSTURES WHILE SITTING ON LEVEL SURFACE				
Balance:	<input type="checkbox"/> Hands-free sitter	<input type="checkbox"/> Hands-required sitter	<input type="checkbox"/> Supported sitter	
Planes	SAGITTAL	FRONTAL	TRANSVERSE	
Pelvis	TILT	OBLIQUITY	ROTATION	
	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral	
	<input type="checkbox"/> Posterior	Lower on the:	Forward on the:	
	<input type="checkbox"/> Anterior	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	
Range:				
None =	<input type="checkbox"/> Fixed	<input type="checkbox"/> Fixed	<input type="checkbox"/> Fixed	
Less than Neutral =	<input type="checkbox"/> Improvable	<input type="checkbox"/> Improvable	<input type="checkbox"/> Improvable	
Beyond Neutral =	<input type="checkbox"/> Correctable	<input type="checkbox"/> Correctable	<input type="checkbox"/> Correctable	
Hips 	FLEXION (Functional)	AD/ABduction		ROTATION
	<input type="checkbox"/> WFL	<input type="checkbox"/> Neutral		<input type="checkbox"/> Neutral
	<input type="checkbox"/> Limited range	ABduction	ADduction	Internal
	R ~ _____ ° L ~ _____ °	<input type="checkbox"/> L <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> R
	<input type="checkbox"/> Fixed <input type="checkbox"/>	<input type="checkbox"/> Fixed <input type="checkbox"/>	<input type="checkbox"/> Fixed <input type="checkbox"/>	
	<input type="checkbox"/> Improvable <input type="checkbox"/>	<input type="checkbox"/> Improvable <input type="checkbox"/>	<input type="checkbox"/> Improvable <input type="checkbox"/>	
	<input type="checkbox"/> Correctable <input type="checkbox"/>	<input type="checkbox"/> Correctable <input type="checkbox"/>	<input type="checkbox"/> Correctable <input type="checkbox"/>	
Trunk	FLEXION/EXTENSION	SCOLIOSIS		ROTATION
	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral		<input type="checkbox"/> Neutral
	<input type="checkbox"/> Lordosis	<input type="checkbox"/> S- Curve		Forward to the:
	<input type="checkbox"/> Kyphosis	Convex to the :		<input type="checkbox"/> L <input type="checkbox"/> R
	<input type="checkbox"/> Fixed	<input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Fixed
	<input type="checkbox"/> Improvable	<input type="checkbox"/> Fixed		<input type="checkbox"/> Improvable
	<input type="checkbox"/> Correctable	<input type="checkbox"/> Improvable		<input type="checkbox"/> Correctable
	<input type="checkbox"/> Correctable	<input type="checkbox"/> Correctable		<input type="checkbox"/> Correctable
Upper Extremities	PRO/RETRACTION	SUBLUXATION		
	<input type="checkbox"/> Neutral	<input type="checkbox"/> Neutral		
	<input type="checkbox"/> Protraction <input type="checkbox"/> Retraction	Subluxation on the:		
	<input type="checkbox"/> Fixed	<input type="checkbox"/> L <input type="checkbox"/> R		
	<input type="checkbox"/> Improvable			
	<input type="checkbox"/> Correctable			
Other relevant postural tendencies and ranges:				
<input type="checkbox"/> photo taken				

SENIORS COMMUNITY WHEELCHAIR LOAN PROGRAM

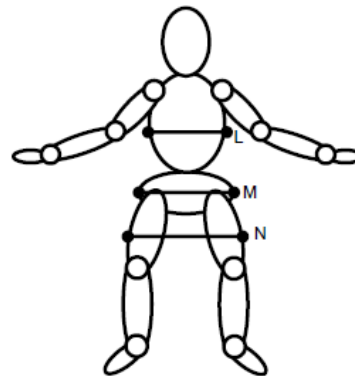
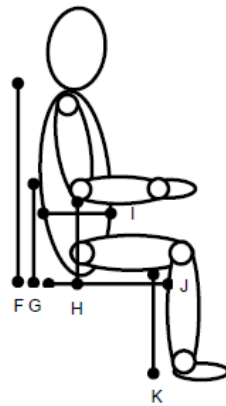
Wheelchair User Name: _____ HCN: _____

POSTURES and RANGES WHILE SUPINE ON MAT			
Planes	SAGITTAL	FRONTAL	TRANSVERSE
	RANGES	OBLIQUITY	ROTATION
Hip Flexion 	FLEXION (Functional) <input type="checkbox"/> WFL <input type="checkbox"/> Limited range R ~ _____ ° L ~ _____ °	<input type="checkbox"/> Neutral Lower on the: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Fixed <input type="checkbox"/> Improvable <input type="checkbox"/> Correctable	<input type="checkbox"/> Neutral Forward on the: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Fixed <input type="checkbox"/> Improvable <input type="checkbox"/> Correctable
	Knee Range 	FLEXION/EXTENSION <input type="checkbox"/> WFL <input type="checkbox"/> Limited range R ~ _____ ° L ~ _____ °	AD/ABduction <input type="checkbox"/> Neutral ABduction ADduction <input type="checkbox"/> L <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> R <input type="checkbox"/> Fixed <input type="checkbox"/> <input type="checkbox"/> Improvable <input type="checkbox"/> <input type="checkbox"/> Correctable <input type="checkbox"/>
Trunk	FLEXION/EXTENSION <input type="checkbox"/> Neutral <input type="checkbox"/> Lordosis <input type="checkbox"/> Kyphosis <input type="checkbox"/> Fixed <input type="checkbox"/> Improvable <input type="checkbox"/> Correctable	SCOLIOSIS <input type="checkbox"/> Neutral <input type="checkbox"/> S- Curve Convex to the : <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Fixed <input type="checkbox"/> Improvable <input type="checkbox"/> Correctable	ROTATION <input type="checkbox"/> Neutral Forward to the: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Fixed <input type="checkbox"/> Improvable <input type="checkbox"/> Correctable
	Upper Extremities	PRO/RETRACTION <input type="checkbox"/> Neutral <input type="checkbox"/> Protraction <input type="checkbox"/> Retraction <input type="checkbox"/> Fixed <input type="checkbox"/> Improvable <input type="checkbox"/> Correctable	Head and Neck
Other relevant postural tendencies and ranges:			
<input type="checkbox"/> photo taken			

SENIORS COMMUNITY WHEELCHAIR LOAN PROGRAM

Wheelchair User Name: _____ HCN: _____

BODY MEASUREMENTS – document all required			
Seat Surface to:	Left	Right	Bilateral
A Top of Head			
B Top of Shoulder			
C Inferior Angle of Scapula			
D Bottom of Ribs			
E Posterior Superior Iliac Spine			
F Occipital Shelf			
- Apex of Kyphosis (not illustrated)			
G Top of Lateral Support			
H Elbows			
I Trunk Depth			
J Upper Leg Length			
K Lower Leg Length			
L Trunk Width			
M Compressed Hip/Greater Trochanter Width			
N Outside of Knees			
Client's	Height:		Weight:



ASSESSMENT SUMMARY

Primary goals of Seating and Mobility System

1. _____
2. _____

SENIORS COMMUNITY WHEELCHAIR LOAN PROGRAM

Wheelchair User Name: _____ HCN: _____

Summary of Findings
 (List of issues specifically affecting seating prescription)

In the following section please include the justification for how the components of the system are integral to the client staying within their home:

Wheelchair Equipment Details	Rationale
Base Manual <input type="checkbox"/> Folding <input type="checkbox"/> Non-folding Power <input type="checkbox"/> Rear-wheel <input type="checkbox"/> Mid-wheel <input type="checkbox"/> Front-wheel <input type="checkbox"/> Power assist	Type: Width: Depth: Height:
Positioning Components <input type="checkbox"/> Tilt <input type="checkbox"/> Manual <input type="checkbox"/> Power <input type="checkbox"/> Other:	Type: <input type="checkbox"/> Not Applicable
Input Device	Type: Location: <input type="checkbox"/> Not Applicable
Critical Angles Seat to Back: Foot rests:	<input type="checkbox"/> Not Applicable
Armrests	<input type="checkbox"/> Not Applicable
Footrests and Plates	<input type="checkbox"/> Not Applicable
Tie Downs	<input type="checkbox"/> Not Applicable
Cushion	Type: Width: Depth: <input type="checkbox"/> Not Applicable
Back	Type: Width: Height: <input type="checkbox"/> Not Applicable

SENIORS COMMUNITY WHEELCHAIR LOAN PROGRAM

Wheelchair User Name: _____ HCN: _____

Wheelchair Equipment Details		Rationale
Pelvic Support	Type: <input type="checkbox"/> Not Applicable	
Headrest	Type: Mounting hardware: <input type="checkbox"/> Not Applicable	
Additional Positional Supports	<input type="checkbox"/> Not Applicable	
Accessories	<input type="checkbox"/> Not Applicable	

Plan

Plan reviewed and approved by client/caregiver: YES NO

Therapist Signature: _____

Name printed: _____

Contact #: _____

CC: Health Records

Note: This form is not yet converted for electronic input.

SENIORS COMMUNITY WHEELCHAIR LOAN PROGRAM



Nova Scotia

Provincial Seating and Mobility Assessment



World Health Organization – Wheelchair Service Provision Steps			
<input type="checkbox"/> 1. Referral and Appointment	<input checked="" type="checkbox"/> 3. Prescription	<input type="checkbox"/> 5. Wheelchair Preparation	<input type="checkbox"/> 7. Training
<input type="checkbox"/> 2. Assessment	<input checked="" type="checkbox"/> 4. Funding & Ordering	<input type="checkbox"/> 6. Fitting	<input type="checkbox"/> 8. Maintenance & Follow-up

Wheelchair User Name: _____ HCN: _____

Date (yyyy/mm/dd): _____

- Informed consent to provide Care Coordinator and Vendor with equipment prescription form
- Client and/or Authorized Representative aware and in agreement with equipment prescription
- Manufacturer's order form attached

Wheelchair Equipment Prescription	
Base Manual <input type="checkbox"/> Folding <input type="checkbox"/> Non-folding Power <input type="checkbox"/> Rear-wheel <input type="checkbox"/> Mid-wheel <input type="checkbox"/> Front-wheel <input type="checkbox"/> Power assist	Type: Width: Depth: Height:
Positioning Components <input type="checkbox"/> Tilt <input type="checkbox"/> Manual <input type="checkbox"/> Power <input type="checkbox"/> Other: _____	Type: <input type="checkbox"/> Not Applicable
Input Device	Type: <input type="checkbox"/> Not Applicable Location:
Critical Angles Seat to Back: Foot rests:	
Armrests	<input type="checkbox"/> Not Applicable
Footrests and Plates	<input type="checkbox"/> Not Applicable
Tie Downs	<input type="checkbox"/> Not Applicable

SENIORS COMMUNITY WHEELCHAIR LOAN PROGRAM

Wheelchair User Name: _____ HCN: _____

Cushion	Type: _____ <input type="checkbox"/> Not Applicable Width: _____ Depth: _____
Back	Type: _____ <input type="checkbox"/> Not Applicable Width: _____ Height: _____
Pelvic Support	Type: _____ <input type="checkbox"/> Not Applicable
Headrest	Type: _____ <input type="checkbox"/> Not Applicable Mounting hardware: _____
Additional Positional Supports	_____ <input type="checkbox"/> Not Applicable
Accessories	_____ <input type="checkbox"/> Not Applicable

Plan:

- Vendor to contact therapist when equipment available for fitting.
- Therapist to complete visit with the client and vendor for fitting and set-up of wheelchair.
- Therapist to provide training and follow-up once wheelchair in place.

Therapist Signature: _____

Name printed: _____

Contact #: _____

CC: Health Records
Care Coordinator
Vendor