

# Victorian Aids and Equipment Program Wheelchairs and Scooters report and prescription form

***This form is to be used for Victorian Aids and Equipment electric wheelchairs, scooters and manual wheelchairs. Use of other formats is acceptable provided it addresses all areas of concern.***

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Equipment will be re-issued where suitable items are available from A&EP stocks

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<b><i>Applicant:</i></b>		<b><i>Please tick if attached:</i></b>	
Last Name:		First Name:	
Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth:	
Address:			
		Postcode:	
Tel:		Mobile:	
Parent/Carer NOK Name:		Ph:	
C/Mgr Name:		Ph:	
		Clinical Report	
		Supplier quote	
		Application/Eligibility form	
		Doctor's signature/letter	
		Application for pressure cushion	
<b><i>Wheelchair/Scooter recommended</i></b>			
Customising required    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete section on pages 8-9			
Supplier:		Phone	
Price:			
Is Additional Funding required?		Is the funding Organised & From Whom?	
<b><i>Urgency</i></b>			
<input type="checkbox"/> critical to the safety of the client		<input type="checkbox"/> critical in supporting the current care / living arrangements	
<input type="checkbox"/> critical to the maintenance of health and functional abilities		<input type="checkbox"/> preferable for quality of life	
<b><i>Prescriber: (please print) Occupational Therapist / Physiotherapist</i></b>		Date:	
Name of Prescriber:		Contact Hours:	
Profession: OT / PT		Tel:	
Organisation		Mobile:	
Address:		Postcode:	
Signature:		Fax:	
		Email:	

<b>Social Situation</b>	<b>Yes/No</b>	<b>Comments</b>
<i>Does the Client live alone?</i>		
<i>Does the client have a Carer?</i>		
<i>Does the applicant require assistance?</i>		
<i>What is the Carer's capacity to assist?</i>		
<i>Does the Carer drive a car?</i>		
<i>Does the applicant have a social support network?</i>		
<i>Does the applicant have a ½ price taxi voucher?</i>		

**Disability and/or relevant medical history**

<b>Diagnosis:</b>	
<i>Client's Height:</i>	<i>Client's Weight:</i>
NB: Exact weight essential if likely to be near/ <b>over</b> 100kgs: _____	
Comment:	

**FUNCTIONAL LIMITATIONS and CLINICAL NEED**

Please comment, in functional terms, on the following as relates to influence on ability to OPERATE a wheelchair/scooter, indications for need for wheelchair, manual versus powerchair.

<b>Description</b>	<b>Comment</b>	
	<b>Right</b>	<b>Left</b>
<b>Upper Limb Function</b>		
<i>Strength</i>		
<i>Range of Movement</i>		
<i>Tone</i>		
<i>Co-ordination</i>		
<i>Endurance</i>		
<i>Sensation</i>		
<i>Reaction Time</i>		

<b>Lower Limb Function</b>	<b>Right</b>	<b>Left</b>
<i>Strength</i>		
<i>Range of Movement</i>		
<i>Tone</i>		
<i>Co-ordination</i>		
<i>Endurance</i>		
<i>Sensation</i>		

### **Trunk and Neck Function**

<i>Pain</i>	
<i>Range of Movement</i>	
<i>Posture / Deformity</i>	
<i>Balance</i>	
<i>Endurance</i>	

### **Hearing**

<i>General comment</i>	
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### **Vision**

<i>General comment</i>	
<i>Scanning</i>	
<i>Acuity</i>	
<b><i>If a significant Hearing or Visual problem is detected a specialist's report is required</i></b>	

### **Transfers**

<i>Type of transfer</i>	
<i>Amount and type of Assistance Needed</i>	
<i>Aids used</i>	

### **Mobility**

<i>How far can a client ambulate in metres?</i>	
<i>Amount of Assistance Needed?</i>	
<i>Type of assistance, including aids used?</i>	

**Pressure Care**

<i>Identify clinical issues</i>	
<i>Reasons for needing a pressure cushion</i>	
<i>Is the applicant currently using a pressure Cushion?</i>	
<i>If yes please identify the cushion currently in use</i>	
<i>Will a pressure cushion be applied for through A&amp;EP?</i>	

**Communication**

<i>Communication?</i>	
<i>Language problems?</i>	
<i>Speech problems?</i>	
<i>Is an electronic communication device needed while using a wheelchair?</i>	

**COGNITIVE FUNCTION**

<i>Comprehension of Instruction / New Learning</i>	
<i>Visual Perception</i>	
<i>Neglect / Inattention</i>	
<i>R/L discrimination</i>	
<i>Visuospatial problems</i>	
<i>Memory</i>	
<i>Planning &amp; reasoning</i>	
<i>Problem solving</i>	
<i>Concentration</i>	
<i>Insight</i>	
<i>Confidence</i>	
<i>Behavioural problems / Impulsiveness</i>	
<i>Error of Recognition</i>	
<i>Reaction Time</i>	

**WHEELCHAIR HISTORY**

Does applicant currently have a wheelchair? Yes  No

If yes, make/model of current wheelchair: \_\_\_\_\_

Owned by Client? Yes  No  If no, owned by: \_\_\_\_\_

Reasons why current wheelchair is not **appropriate**: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INTENDED USE**

Environment to be used in: *(indicate if more than one)*

Indoors  Outdoors  Home  School  Community  Other

Terrain - Hilly  Flat  Other  \_\_\_\_\_

Anticipated frequency of use: - Daily  Weekly  Occasional

Wheelchair dependent

Can the client self propel a manual wheelchair? Yes  No

**If yes**, how far? \_\_\_\_\_

Can access to community be provided by the provision of a manual wheelchair which once transported to community by car/taxi/carer, be then propelled by self/carer: Yes  No

**If no**, why not \_\_\_\_\_

Does the applicant drive a car? Yes  No

Does the applicant have access to car transport *ie spouse/family/carer?* Yes  No

Will the applicant remain seated in the wheelchair during vehicle transport? Yes  No

If yes, have relevant Australian Standards been considered, for example;

AS2942 wheelchair occupant restraint for vehicles?

Purpose of wheelchair/scooter requested (*including essential ADLs, social, Public transport*)

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### TRIALS

It is recommended that more than one type of chair or scooter is trialled. Please provide trial details for chair/scooter **not recommended** including trial date, equipment trialed and outcome.

Equipment trialed/Brand	Date	Outcome

### Recommended Wheelchair/Scooter:

\_\_\_\_\_

Trial date: \_\_\_\_\_

Present at trial: Therapist  Supplier  Other: Names: \_\_\_\_\_

Wheelchair/scooter trialled:

Exactly as recommended  Other

\_\_\_\_\_

Reissue  Asset No: \_\_\_\_\_

### Alternative Brands trialled & suitable? Yes / No . Why? Please Comment

Features/Brand	Comment

Comments below need to include safety and independence level, type of assistance required ie verbal / physical supervision.

**APPLICANT'S HOME - ACCESS TRIAL: Trial Date: \_\_\_\_\_**

Please comment in detail. If uncertain, please repeat trial / assessment.

Where appropriate please include reference to:

Home Access - front	
Home Access – rear	
Bathroom	
Toilet	
Bedroom	
Kitchen	
Living areas	
Laundry	
Corridors / Doorway widths	
Turning	
Floor Surfaces	
Outdoors	
Ability to manage Charger	

Are home modifications required to suit wheelchair? Yes  No

Has/will an application be placed re above modification? Yes  No

Is a suitable wheelchair storage area available?  
*(A secure, enclosed area with power point available for electric wheelchair/scooter is recommended)?*  
 Yes  No

Note: If applicant intends to purchase new storage facility, do not proceed until advised the application has been successful.

**COMMUNITY TRIAL: Trial Date: \_\_\_\_\_**

Please comment in detail. Please repeat trial / assessment if necessary.

Where appropriate please include ability to **safely** traverse

<i>Footpath</i>	
<i>Crossing roads/intersections</i>	
<i>Crossing at traffic lights</i>	
<i>Selecting appropriate crossing places</i>	
<i>Ramp / Incline use including stopping</i>	
<i>Crowded streets</i>	
<i>Obstacles</i>	
<i>Uneven terrain / grass</i>	
<i>Car access</i>	
<i>Taxi access</i>	
<i>Cambers</i>	
<i>Public transport</i>	
<i>Dismantling chair</i>	

Safety and independence:                      Unsupervised                       Supervision essential

If supervision required, who will provide this? \_\_\_\_\_

***SPECIFICATIONS INCLUDING CUSTOMISING***

<u>Manual</u>		<u>Electric</u>		<u>Scooter</u>	
Self-propelled – <b>RWD, FWD</b>		Rear wheel Drive		3 wheels	
Transit		Mid wheel drive		4 wheels	
Amputee		Other		Either appropriate	
Seat Type:		Seat Width:		Seat Depth:	
Back rest Type:		Back rest height			
Armrests:		Leg rests			
Upholstery		Footplates			
QR Axles		Brakes:			
Charging point		Speed			
Drive Controls		Battery type / size – why?			
Castors		Accessories			

**Customisation** –Please comment including justification and the relevant areas below.

Frame – eg TIS, reclining	
Seating / supports	
Ability of Chair to grow-width, depth, height	
Anticipated Length of client's use of wheelchair	
Mounting systems	
Other	

**Is a seat belt or restraint recommended & why?**

Yes  No

**Is the client/carer trained, able & available to remove it in an emergency?**

Yes  No

**Is a tray required?**

Yes  No

**Is the client/carer trained, able & available to remove it in an emergency?**

Yes  No

*Comment on reason for tray and type requested.*

If training is required in order for client to demonstrate independent and safe ability, please complete training prior to submitting application.

*Does the applicant have the ability to operate the wheelchair/scooter in a safe and independent manner at home and in the community?*

**Prescribers Signature:**

**Date:**