

Wheelchair information form for Health Care Providers

Customer name: _____ Registration #: _____

Date submitted: _____ Health Care Provider Name: _____

Professional Designation: _____ Health Care Provider phone number: _____

INSTRUCTIONS:

- One form completed per piece of equipment being added.
- Incomplete forms will be returned.
- Please fax to (204)986-6555 or email: transitplusOT@winnipeg.ca

Wheelchair information


1) Are you adding a new wheelchair or updating existing wheelchair on file? New ☐ Existing ☐

2) Are you adding a manual wheelchair or power wheelchair: Manual ☐ Power ☐

3) Make and model: _____

4) Wheelchair Dimensions: Overall width _____ (inches) Overall length _____ (inches)

5) Floor to shoulder height when seated in wheelchair: _____ (inches)

6) Does this equipment have WC-19 stickers and  Yes ☐ No ☐
WC-19 tie down brackets?

7) Are there transit tie down brackets (not WC-19) on the equipment? Yes ☐ No ☐

8) If yes to question 6 or 7, please describe location, confirm presence of 4 brackets, and if there is a securement hook symbol on or near the bracket?

If possible please include photos of the wheelchair taken from a low angle at front, rear and sides of wheelchair.

9) Where is the wheelchair ordered from? (e.g. MB Possible, vendor, etc.) _____

10) Are there any additional features to the chair? (e.g. tilt/recline, extended foot rests, hemi height, lap tray, communication device, oxygen, specialized positioning/supports, camber on wheels) _____

11) Will this be their primary mobility aid used during transportation? Yes ☐ No ☐

If no, list primary mobility aid: _____

Customer Information:

1) Can they transfer to a vehicle seat independently? Yes ☐ No ☐

2) Current weight (required due to capacities on ramps/lifts/vehicle seats): _____

3) Has use of a lap belt or positioning belt been recommended for use? Yes ☐ No ☐

If yes, please explain. _____



Pick-up location Information:

1) Is there a ramp, lift or flat entrance at the front of the residence?

Yes ☐

No ☐

2) If no, are there stairs that they must use to enter/exit their residence?

Yes ☐

No ☐

NOTES: Transit Plus provides front street service. If ramp/lift or accessible entrance is not located at front of their residence, further information will be required.

Additional information: _____

Health care provider confirms the following conditions:

- Reviewed user manual for wheelchair for information regarding transportation and securement. ☐
- Provided education to client regarding wheelchair transportation safety
(e.g. ride safe brochure, Highway Traffic Act). ☐
- Advised client that more information and/or an inspection at Transit Plus may be required to
confirm if wheelchair meets transportation requirements. ☐
- Health Care provider Signature and date ☐

Signature: _____ Date: _____

If you have any questions when completing this form please contact **Transit Plus Occupational Therapists** at (204) 806-5024.